

# Final Report: Independent Assessment of New Jersey's Children's Behavioral Health Care System

October 2006

Submitted to the New Jersey Division of  
Child Behavioral Health Services



*Louis de la Parte*  
**Florida Mental Health Institute**

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# Executive Summary

The January 2000 New Jersey Department of Human Services (DHS) Concept Paper, *The Children's Initiative Concept Paper*, detailed key elements for system reform and the development of a system of care for children with emotional and behavioral disturbances and their families. The *Concept Paper* (State of New Jersey, 2000) articulated the values and philosophy of a system of care as well as the structural components, financial resources, assessment, access and service array changes that would be employed to operationalize those values and principles. The concept paper called for the development and integration of strong family support organizations to bring support, advocacy, voice and choice to families and to influence state policy; a state-wide contracted system administrator to manage assessment, access/entry, referral, and utilization components; care management organizations to provide intensive care management for children experiencing the most serious mental and behavioral health issues; an expanded array of services including expanded community-based, home-based, and crisis services; and the integration of existing community services into this new system design.

The reform was ambitious and virtually unprecedented in its statewide scope and commitment to individualized, integrated, culturally competent, family-driven services for the children and youth with the most complicated behavioral health needs. The reform aimed to improve access to behavioral health services through uniform screening, a single point of access, and financing strategies to significantly increase the availability of Medicaid funding to develop an expanded array of community-based and in-home services.

In 2006 the State of New Jersey contracted with the Louis de la Parte Florida Mental Health Institute, University of South Florida for an independent assessment of its evolving children's behavioral health system. The focus of the independent assessment is not on the foundational principles of the reform, but rather on its implementation. This report contains the findings and recommendations of the assessment. The report is organized into chapters that address the following research questions:

- Is the governance structure at the state and local levels of the system of care clear, consistent with the system's goals and objectives, and inclusive of other child serving entities?
- Is the assessment process for identifying the mental health needs of children and their families consistent with national best practices, and is the process effectively implemented?
- Does the system respond effectively to the behavioral health needs of multi-system involved children and their caregivers, including children in the child welfare, juvenile justice, and developmental disabilities systems?
- Does the case management system promote good care management practices, such as continuity of care, and is the system reflective of national best practice case management models?

- 
- Is the service array responsive to the identified needs of children and families?
  - Does the system include and/or promote the use of evidence-based and promising practices?
  - Are families involved as partners, at both the system level and in the delivery of services?
  - Is the system appropriately sized in relation to prevalence estimates data, geographic equity in distribution of services and resources, and sizing estimates methodologies used by other states?

While this report is organized into chapters based on the research questions, it is important to remember that the children's mental health system of care is more than the sum of its component parts. The functioning of the individual components is, of course, vital to the success of the entire system. However, the interaction of these components is equally as important to the overall operation and viability of the system. Systems are dynamic and never linear; changes in one component will have reverberating and unanticipated effects across the system. A strong governance structure, strategies based on functions versus form; and timely, accurate data flowing throughout the system will help ensure that even unplanned outcomes will not destabilize the system.

Below is a brief summary of each chapter, concluding with a set of policy and practice recommendations related to the findings for each research question. Chapter summaries are followed by a set of overarching developmental principles and recommendations that may facilitate improvements in the implementation of a complex system reform.

The first chapter covers four related topics: state level governance structure, system of care development, interagency collaboration at state and local levels, and local level governance structure. The primary recommendation of this section is that New Jersey needs to develop inclusive and effective governance bodies, at both the state and local levels. The role of executive staff of the newly created Department of Children and Families is to provide strong leadership in the creation of a shared vision and a strategic plan to address the mental health needs of all children and their families.

Effective governance bodies need accurate and timely data regarding system performance and child and family outcomes. The second chapter addresses New Jersey's Continuous Quality Program and uses a five-step framework: adoption of outcomes and standards, incorporation of quality assurance throughout the system, gathering data and information, analysis of data and information, and use of analyses and information to make improvements. Key recommendations are to develop a common set of outcome and performance standards that are well articulated in all service contracts, and to expand the accuracy and usefulness of data for planners and decision-makers.

The decision-making capacity of governance bodies should be grounded in reliable and valid data regarding the needs and strengths of children and families entering the service system. Chapter 3 reviews the assessment process for the children's behavioral health system, including the status of the information management and decision support (IMDS) system,

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application of the IMDS instruments, and the training and certification process. A series of mid-course course corrections are identified regarding the assessment system, with the goals of increasing stakeholders' understanding of the process, responding to legitimate user concerns, and restoring confidence in the capacity of the assessment process to inform practice decisions and guide the evolution of the system.

The fourth chapter reviews what happens to a child and family after the assessment process. The chapter offers an assessment of New Jersey's care management system, including the access and referral process and capacity issues. This chapter also reviews New Jersey's care management system in relation to the evidence base and national best practices in children's mental health case management and in the context of implementation timelines. Strengths, challenges, and recommendations are offered at the practice, county, and state levels.

The chapter on service array continues to focus on the service system and explores issues related to New Jersey's definition of its target population, accessibility to services, availability and appropriateness of services for specific populations, and gaps in the service array. The chapter recommends a review of the target population definition to clearly specify the children who will be served, the development of appropriate specific services for sub-groups of children (e.g., children with mental health and developmental disabilities, fire setters, children with sexual perpetrating behaviors), and a targeted review of the appropriateness of the use of intensive in-home care and behavioral assistants services and a review of selection criteria and credentialing of the practitioners offering these services.

The sixth chapter turns attention to the use and promotion of evidence-based practices in the children's behavioral health system. This chapter recommends a review of successful statewide initiatives to implement evidence-based practices and programs, careful selection of new evidence-based programs by a broad-based workgroup of state and local system partners, and the investment of time and resources in implementation.

The seventh chapter brings in the voices of families and direct service providers, using the findings from Child and Family Reviews in three counties at varying stages of implementation to assess the involvement of families/caregivers in child assessment and treatment planning, and the responsiveness of services to the identified needs of children and their families. Recommendations include a stronger focus on family engagement in both assessment and treatment planning, more involvement of family support organizations with care management entities in the family engagement and support process, and clearer guidelines and emphasis on gathering data related to family and youth satisfaction.

The final chapter addresses the question of whether the system is appropriately sized in relation to prevalence estimates, geographic equity, and in comparison with other states' sizing estimates methodologies. The analyses indicate that New Jersey has reduced the number of children using residential care and reduced variation in the rates of utilization of residential care across counties but that the level of access to services remains a concern and varies greatly across counties.



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In addition to the policy and practice recommendations identified in each chapter of the report, the following overall recommendations will facilitate forward movement in New Jersey's implementation of its children's behavioral health system.

**First, at all costs avoid another massive “system reform” effort.** System partners report that they are just beginning to “get it” and to understand the functions and goals related to systems of care. System change takes years to accomplish and implementation is actually in very early stages for much of the state of New Jersey (e.g., one county with 18 months' experience, four counties with 14 months' experience and five counties with only 9 months of experience). It is often tempting to respond to criticism and systemic problems by demonstrating “strong leadership” and making sweeping changes. However, the reality is that functional systemic change takes sustained, active leadership at the state level and strong partnerships and vertical integration with the local level. To fully implement and sustain reforms, there must be purposeful attention to communication, feedback loops, and financing strategies consonant with effective service delivery, the development of trusting relationships and an increasing reliance on data for decision-making. As one survey respondent noted: “Every redesign creates a gap in implementation — leaving issues simmering until a new plan is in place.”

**Second, build on the strengths of the system reform efforts in the children's behavioral health system that have been crafted, initiated, and operationalized.** As noted throughout the report, there are many committed partners, best practice structures, training initiatives, data system developments, and service expansion successes. The flaws in the system are related to typical implementation issues that plague most large scale reform efforts, including identifying needed services and resources, sustaining “buy in”, vertical communication between state and local entities, horizontal communication issues among providers at the local level, and in general, getting operations to match rhetoric. There are “best practices” in care management and collaboration at the local level that can be identified and more systemically shared so that learning is leveraged and policy changes grounded in practice reality.

**Third, structural change within the existing system needs to be carefully considered in light of the overall system functioning and requires thoughtful analyses of the “problem(s)” that such changes are intended to remedy.** Rarely are problems adequately addressed solely through changes in structure. Frequently there are unanticipated consequences that emerge when structural changes are not analyzed with regard to unintended impacts on the system as a whole. Each proposed change needs to be carefully analyzed with respect to the following:

- What is the problem that we want to solve? Whose problem is it?
- What data or evidence do we have regarding the dimensions of the problem? What early indicators will tell us if we are solving the problem or making it worse?
- How is that problem related to system functioning and to other problems and/or other strengths?



- 
- Which stakeholders need to be involved in crafting a solution? Are there ways to hear the voices of all the “partners” who would be impacted by the change? Is the impact on and voice of youth and families central to the analysis?
  - What would be the benefits? Are there potential unintended positive outcomes? Are there potential unintended negative outcomes? How would such positive outcomes be leveraged and how might possible negative outcomes be ameliorated and tracked?
  - What resources and procedures will be required for effective implementation and how available are they? How will we know if the intervention or new policy is being implemented as intended? How will we support implementation?

Addressing such questions increases the likelihood that desired outcomes (function) will drive structural changes (changes in form) and that there will be “buy in” from stakeholders as well as a strategy for implementation.

***Fourth, where appropriate, consider the development of “innovation zones” to try out proposed improvement strategies.*** Since there is a relatively common set of services, structures, strengths and challenges across the state, it may be strategically advantageous to test out policy and service changes by partnering with counties to temporarily change policies and procedures and create new ways of work. For example, given the strong belief in “home rule” in New Jersey, different counties may want to try varying organizational arrangements in order to carry out the report’s recommendations regarding the implementation of local level governance structures. Innovation zones would need to have good data systems in place to monitor the specific impact of the innovation and to measure the degree to which the innovation is actually implemented. The zones also would need direct access to state leadership with the expectation that barriers would be addressed by the state and the county. This approach requires strong leadership and the clear message that there is a dedicated effort to finding solutions to systemic problems that would then be built into funding, policy, procedures, service arrays and accountability systems. Rather than viewing these efforts as “pilots”, the common message from state and county alike would be that collectively we are out to solve an agreed upon problem and that the key functional elements of successful solutions will have systemic implications for the evolution of New Jersey’s children’s behavioral health system and the implementation of a statewide system of care. ■



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# Introduction

Since 2001 the New Jersey Department of Children and Families has implemented a reform of the child behavioral health system based on the values and principles of systems of care (Stroul & Friedman, 1996). The State of New Jersey contracted with the Louis de la Parte Florida Mental Health Institute, University of South Florida for an independent assessment of their children's behavioral health system. As noted in the Request for Qualifications, the focus of this independent assessment is not on the foundational principles of the reform, but on its implementation. The implementation and sustainability of large system reforms, such as statewide systems of care, is complex and challenging. This reality was addressed by the President's New Freedom Commission on Mental Health (2003), which clearly articulated that state mental health systems have far to go in reaching the goal of transformation.

At both the federal and state levels over the past 20 years, systems of care have been the predominant policy response to the challenge of offering appropriate services to children with serious emotional disturbances and their families. A recent review of relevant state policies indicated that most states have statutes supporting the development of community-based systems of care (Evans & Armstrong, 2003). Of 39 states that responded to a survey, all but five respondents stated that they were striving to implement systems of care. Another recent review of special mental health commissions from 13 states that studied their status between 1997 and 2001 (Friedman, 2002) found that these states reported major implementation challenges in their efforts to develop systems of care.

In response to the Request for Qualifications, the assessment addresses the following research questions:

- Is the governance structure at the state and local levels of the system of care clear, consistent with the system's goals and objectives, and inclusive of other child serving entities?
- Is the assessment process for identifying the mental health needs of children and their families consistent with national best practices, and is the process effectively implemented?
- Does the system respond effectively to the behavioral health needs of multi-system involved children and their caregivers, including children in the child welfare, juvenile justice, and developmental disabilities systems?
- Does the case management system promote good care management practices, such as continuity of care, and is the system reflective of national best practice case management models?
- Is the service array responsive to the identified needs of children and families?
- Does the system include and/or promote the use of evidence-based and promising practices?
- Are families involved as partners, at both the system level and in the delivery of services?

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- Is the system appropriately sized in relation to prevalence estimates data, geographic equity in distribution of services and resources, and sizing estimates methodologies used by other states?

## Methods

A mixed methods approach using both qualitative and quantitative strategies was used for the independent assessment. The methods included focus groups, in-person interviews with key stakeholders, a web-based survey of a sample of individuals within New Jersey’s children’s behavioral health system, and analysis of expenditure and utilization data from New Jersey and other similar states and localities.

## Focus Groups

### Process

A focus group is a guided group interview used to capture information and perspectives from participants regarding a specific topic of interest. The focus group process allows for the presentation of a small number of questions to be addressed and enables participants to share their views in a relaxed setting in a collaborative and respectful way. Due to time constraints, focus groups were planned only with groups identified as working in, affiliated with, or employed by the New Jersey Division of Children’s Behavioral Health Services (DCBHS), or those that have been identified as having knowledge about certain aspects of DCBHS, and that already had a standing meeting in place and occurring during the timeframe of the evaluation. Focus group questions were developed based on the overall research questions. All groups were able to respond to sets of questions presented to all groups, and questions specific to the group being interviewed (see Appendix A for focus group questions presented to participants). Participant groups, number of attendees, and time/date/length of the completed focus groups are included below (**Table1**).

<b>Table 1.</b> <b>Description of Participants in Focus Groups</b>			
<b>Date of Contact</b>	<b>Group Name</b>	<b>Number of participants</b>	<b>Detail</b>
5/11/06	Youth Case Management Program Supervisors	13	2 groups: Each group contained low, medium, high implementation status counties*
5/11/06	Care Management Organization Directors	14	2 groups: Each group contained low, medium, high implementation status counties*
5/18/06	Mobile Response Stabilization Services Directors	13	2 groups: Each group contained low, medium, high implementation status counties*
5/18/06	Family Support Organization	10	1 Group
5/18/06	Team Leaders	10	1 Group
6/23/06	New Jersey Association of Children's Residential Facilities	7	1 group via telephone
6/26/06	Judiciary	10	1 group via telephone
6/27/06	County Mental Health Association	10	1 group via telephone

## Data Analysis

Focus groups were tape recorded for accuracy and tapes were transcribed. In addition, all notes taken by the focus group facilitators were typed and reviewed for accuracy. Study team members coded all focus group transcriptions and notes to gather themes, patterns and identified relevant quotes for inclusion in the final report.

## Interviews with Key Stakeholders

Interviews were conducted with over 200 individuals who play major roles in the planning and provision of services to children with behavioral health problems in New Jersey (See **Appendix C** for a list of interviewees). These individuals were identified by the Division of Children's Behavioral Health Services (DCBHS), the study's Advisory Group, and interviewees. Semi-structured interview protocols were used for the interviews.

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## Internet Survey

### Process

Internet surveys were utilized to gather information from a sample of individuals identified as working in, affiliated with, or employed by an agency within DCBHS or those that have been identified as having knowledge about certain aspects of the DCBHS. The cross-sectional survey method allows for the collection of information from participants at one-point in time and allows for a large number of individuals to participate. Two sampling methods, snowball sampling and convenience sampling, were used to select samples of participants for internet surveys. In addition, the samples included participants who contacted the researchers and volunteered to participate in the survey process.

Internet surveys were developed and distributed through the use of Survey Monkey internet survey development software ([www.surveymonkey.com](http://www.surveymonkey.com)). The use of Survey Monkey software allows for survey creation, collection and data analysis while maintaining confidentiality of participants and protection of data through encrypted security measures. Three distinct surveys were created for use in the evaluation: one overall survey, one survey distributed to a sample of case manager supervisors of the Division of Youth and Family Services (DYFS), and one survey distributed to a sample of both law guardians and juvenile justice attorneys. Three surveys were utilized to allow for the use of specific questionnaires for specific samples and for ease of completion on the part of participants. All questionnaires included open-ended/completion questions and closed-ended questions (checklists, scaled items, and Likert-type items; please see **Appendix B** for survey instruments). Total response rate for the survey was 34% with 113 participants agreeing to complete the survey and 108 participants actually continuing on to complete survey questions (5 agreed but did not complete questions regarding role/county which prevented them from continuing the survey). Overall, 318 emails with the survey link were sent to potential participants (348 sent, 30 bounced back due to inaccurate email addresses). Due to the small response rate and similarity of survey, the DYFS Supervisors of case manager supervisors survey was combined with the overall general survey. The number of surveys distributed, total number of responses (with response rate), and the response rate of specific system groups responding are included below in **Table 2**.

<b>Table 2.</b> <b>Description of Internet survey Groups and Response Rates</b>				
<b>Group</b>	<b>Number Asked</b>	<b>Number Responded</b>	<b>*Group Response Rate</b>	<b>Percent of Total Response</b>
CMO Case Manager Supervisors	21	7	33%	6.5%
CMO Directors	15	11	73%	10.3%
CSA Personnel	12	1	8%	<1%
FSO Directors	14	11	79%	10.3%
Mental Health Administrators	16	8	50%	7.5%
MRSS Directors	15	9	60%	8.4%
MRSS Supervisors	11	1		<1%
NJAMA Providers and Other Providers	133	32	24%	30%
State QA/QI Personnel	25	9	36%	8.4%
Team Leaders	14	8	57%	7.5%
YCM Agency Directors	25	7	28%	6.5%
YCM Case Management Supervisors	23	3	13%	2.8%
**DYFS Supervisors of Case Manager Supervisors	24	1	4%	<1%
*Not an accurate percentage. Survey participants identified their role on the survey. The self-identification may not have matched the role attributed to an individual by the evaluation team. For example, while listed on the evaluation team's YCM agency Director list, the participants may have self-identified with either the YCM agency Director role or the provider role.				
** Due to the small response rate, this survey was combined with the overall survey sent to the other participant groups included on the table.				

A separate survey was developed and sent to law guardians and juvenile justice attorneys. Information pertaining to this survey is included in **Table 3**.

<b>Table 3.</b> <b>Description of Internet Survey of Law Guardians</b> <b>and Juvenile Justice Attorneys</b>			
<b>Group</b>	<b>Number Asked</b>	<b>Number Responded</b>	<b>Response Rate</b>
Law Guardians and Juvenile Justice Attorneys	22	15	68%

## Data Analysis

Tools embedded in Survey Monkey allow for the analysis of the closed-ended survey questions (checklist, scaled items, Likert-type items) and provide results and graphs in ready to use formats (percentages, rankings, etc.). Survey Monkey also allows the user to utilize filter parameters to analyze data in multiple ways, such as by role of participant. Data gathered from open-ended research questions were read and reviewed for themes and patterns by all study team members who utilized survey data.

## Review of Existing Documents

Desk review of a number of documents related to New Jersey's children's behavioral health system was conducted by all study team members:

- *The Children's Initiative Concept Paper* (State of New Jersey, 2000), and: *A New Beginning: The Future of Child Welfare in New Jersey* (State of New Jersey, 2004);
- Child Welfare Panel Monitoring reports, and the July 2006 Settlement Agreement;
- *Final Report: Child Welfare Transition Policy Group, prepared for Governor-elect Jon S. Corzine*, (2006);
- Several CSA Weekly Updates; materials developed by the CSA to explain the role of the CSA in New Jersey to Independent Assessment Team Members; and the CSA power point presentation: CSA Overview (April 2006);
- *Sizing Project Report* (Dougherty Management Associates, Inc., 2006; Chris Marics technical report, DCBHS, 2006);
- A variety of training announcements; a catalogue of trainings offered; training curricula; and copies of training power point presentations from the University of Medicine and Dentistry of New Jersey's Behavioral Research and Training Institute;
- Draft Affiliation Agreement between the Office of Children's Services' Divisions of Child Behavioral Health Services, and Youth and Family Services, and The Division of Developmental Disabilities (February 2006)



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- Reports on the NJ Child Behavioral Health System:
    - *Assessment of the First Three Care Management Organizations of the New Jersey Children's System of care Initiative at the Three-Month Mark of Implementation* (Human Service Collaborative, June 2001)
    - *Treating Troubled Children: Lessons Learned from New Jersey's Partnership for Children* (Association for Children of New Jersey, May 2004)
    - *Report of Findings and Recommendations, The Ad Hoc Task Force, Assembled to Review New Jersey Children's System of Care Initiative* (Department of Human Services, April 2002)
  - Information about DCBHS from the Department Of Human Services web site and written materials shared by DCBHS staff, including, but not limited to: policies; draft standards (i.e., CIACCs); reports; an overview of services available; the DCHBS Child and Family Guide; Power point presentation: "The Role of the Team Leader in Building a System of care in New Jersey" (April 2006i); and "Mental Health Services Provided by Detention Centers" (7/25/06).
  - *The Office of the Child Advocate Report*, Arthur Brisbane Child Treatment Center Investigation;
  - *The Quarterly Service Review Protocol* (Human Systems and Outcomes, Inc., January 2006);
  - Documents shared by the New Jersey Association of Mental Health Agencies, Inc. (e.g., Summary of Training Offered, copies of editions of njama news, Mental Health, and A Wise Investment in People, Communities and Families)
  - The State of New Jersey 2005–2007 Community Mental Health Block Grant Application.
  - All IMDS assessment tools, manuals, and algorithms
  - DCBHS clinical guidelines
  - Treatment Plan, Crisis Plan and Joint Care Review forms and instructions
  - CD and web-based training and certification for the assessment tools
  - Annual reports (04/05 and 05/06), training catalogue, announcements, curricular overviews, power point presentations, and reports provided by the Behavioral Research and Training Institute of UMDNJ.
  - Child and Adolescent Needs and Strengths (CANS): Instrument, manuals, training materials, presentations and published papers, etc.
  - Other commonly-used outcomes assessment instruments, such as CAFAS, Child Functional Assessment Rating Scale (CFARS), CALOCUS (CASII), and CBCL as well as numerous published and unpublished research and monographs on assessment tools used in children's behavioral health care.
  - *An Update on New Jersey's Statewide Implementation of IMDS Application. New Jersey Division of Child Behavioral Health Services (DCBHS)* (Calawan, May 2005)

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- *The Needs of Children Referred into CMO within the New Jersey Children's Initiative: An analysis of selection characteristics.* (Lyons, January 2003).
  - *Mobile Response and Stabilization System (MRSS): Initial Report on the Decision Making and Outcomes Using the Crisis Assessment Tool.* (Lyons, May 2003).
  - *Care Management Outcomes Study* (Value Options)
  - Data reports available through Value Options web portal and orientation packet prepared by Value Options for the Independent Assessment Team
  - *A Proposed Methodology for Sizing New Jersey's System of Care* (Marics, Martin, Vaughan, & Vietze, 2006)
  - *Assessment of the First Three Care Management Organizations of the New Jersey Children's System of Care Initiative at the Three-Month Mark of Implementation* (Human Service Collaborative, June 2001)
  - *Treating Troubled Children: Lessons Learned from New Jersey's Partnership for Children* (Association for Children of New Jersey, May 2004)

## Organization and Terminology for the Report

The organization of the report is centered on a set of chapters that correspond to the research questions identified earlier: governance, family involvement at the system level, quality assurance, assessment of children and families, care management, service array, use of evidence-based practices, family involvement in service planning, and sizing of the system. Each section begins with an introduction to the topic, a description of relevant background and current status, findings of the independent assessment including both strengths and challenges, and a set of policy and practice recommendations.

*The Children's Initiative Concept Paper* (State of New Jersey, 2000) that served as the foundation for what is referred to in this document as 'the children's behavioral health system', used the terminology 'system of care' to describe the new system being developed for children with serious emotional disturbances (SED), and their families. Other stakeholders appeared to utilize the term "system of care" to refer only to the new services, supports and structures that have been developed as a result of the children's behavioral health improvement and expansion initiative begun in 2000 (i.e., reform effort). For the purposes of this independent assessment report, the terminology used will be 'children's behavioral health system' to describe the services, supports and structures in place to serve children with SED, and their families, throughout New Jersey. ■

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# Chapter 1: Governance

## Research Question:

- **Is the governance structure at the state and local levels of the system of care clear, consistent with the system's goals and objectives, and inclusive of other child serving entities?**
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## Introduction

Successful implementation of children's system of care initiatives by government entities on the state, regional and county/local levels, requires strong governance infrastructures.

Sheila Pires, a nationally recognized expert in governance structures for systems of care, identifies key characteristics for governing bodies (2002):

- Have authority to govern;
- Be clear about what it is governing;
- Be representative;
- Have the capacity to govern;
- Have the credibility to govern; and
- Assume shared liability across systems for the target population.

## Background

The January 2000 New Jersey Department of Human Services (DHS) document, *The Children's Initiative Concept Paper* (State of New Jersey, 2000), outlined nine elements of the DHS reform agenda for children with behavioral health needs and their families. Although successful and sustained implementation of each of the elements required a strong governance structure, three of the elements specifically addressed the role of governance:

- "Install utilization management methodologies that assure rapid access to services and care coordination to ensure ....provider accountability to treatment goals and objectives through a Contracted Service Administrator.
- "Establish the organizational structure for ongoing collaborative planning and system management among all child-serving systems to assure effective integration of policy, resources, and procedures to support an organized system of care for children and families.
- "Re-align services and programs operated directly by the DHS to operate as accountable participants in the new system of care...include...service planning and case management provided by the Division of Youth and Family Services and Mental Health Services." (pp. 5 & 6).

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- The *Concept Paper* identified several new governance structures to ensure that all of the identified elements were implemented. These structures included:
    - “An Executive Oversight Board, Chaired by the Commissioner of Human Services including critical policy and decision-makers among child serving systems for ongoing adjustments of policy and reorganization of resources.
    - “A Stakeholder Implementation Advisory Committee of involved and affected stakeholders for ongoing input.
    - “A Children’s Initiative Management Team that reports directly to the Deputy Commissioner of DHS, with representatives from participating divisions and departments, responsible for a number of areas including, but not limited to, system of care performance specifications, needs-based planning, oversight of system of care operations and identification of issues requiring modification of DHS policy reforms and resource reorganization.” (p. 21)

Stakeholders interviewed for the Independent Assessment Report, shared many of the system level challenges to effective implementation of the reform:

**“Since the publication of the *Concept Paper*, New Jersey has had five governors and five commissioners of the Department of Human Services,”**

...as well as numerous changes in leadership staff within the Department of Human Services and within the different entities responsible for children’s mental health. The name of the State entity responsible for children’s mental health went through various name changes during the past six years (e.g., Children’s System of Care, Partnership for Children, Division of Child Behavioral Health Services), as did the reporting structure for the State entity responsible for children’s mental health (e.g., Division of Mental Health Services, Office of Children and Family Services, Department of Children and Families). In addition, class-action litigation against the State in June 2003, resulted in the development of a plan, *A New Beginning: The Future of Child Welfare in New Jersey* (New Jersey Department of Human Services, 2004) for the comprehensive reform of New Jersey’s child welfare system. The Settlement Agreement that New Jersey reached with the plaintiffs of the class action law suit called for a number of enforceable terms. Several of these enforceable terms became the responsibility of or required collaboration with the State entity responsible for child behavioral health, and necessitated time and attention of State staff responsible for child behavioral health. Stakeholders’ perception was that carrying out the enforceable terms became the focus rather than a more thoughtful process that included both a continuation of the system of care implementation and responsiveness to the child welfare imperatives.

New Jersey’s children’s behavioral health system is still in the early stages of developing a statewide system of care. Although the existing behavioral health system has many strengths, the new service array alone (e.g., care management organizations, family support organizations, mobile response and stabilization services, contracted systems administrator, etc.) does not comprise a system of care. Throughout the Independent Assessment Report, a theme identified by many stakeholders, was the lack of integration of all services and supports for children with serious emotional disturbances (SED), and their families, into a unified system of care. So, although the Independent Assessment Report recognizes that New

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Jersey is developing a system of care, the Independent Assessment Report will refer to and make recommendations for New Jersey's 'children's behavioral health system.

The findings related to governance are divided into the following sections: state level governance structure, system of care development, interagency collaboration at state and local levels, and local level governance structure.

## State Level Governance Structure

### Method

Several methods were utilized to conduct the assessment of New Jersey's state level governance structure for the children's behavioral health system. In addition to the methods noted earlier, information on state governance structures of their children's behavioral health systems, as well as integration of this system into a system of care, with specific reference to their integration of child welfare into their system of care, was gathered for Arizona, Kentucky, Minnesota, New York, Rhode Island and Tennessee, and on local level structures from Albany, New York; Monroe County, New York; New York City, New York; Kalamazoo, Michigan; and Milwaukee, Wisconsin. The following venues were used to gain information:

- Review of documents available on State web sites;
- Review of SAMHSA System of Care Grant applications; and
- Interviews with state/county/city behavioral health staff.

### Findings

Many stakeholders reported that the "seemingly singular focus on child welfare reform activities by state leadership staff" over the past several years, and "the multiple changes in state leadership on all levels," "redirected state child behavioral staff attention away from careful development of the new children's behavioral health system," and away from building and sustaining a strong governance structure that would ensure fully achieving the elements identified in the *Concept Paper* (State of New Jersey, 2000).

All stakeholders interviewed acknowledged that there have been problems in the implementation of the reform efforts begun in 2000. Stakeholders shared many perceptions for why problems developed in the implementation of the new children's behavioral health system. Reasons given for problems in both design and implementation related to governance structure, shared by multiple stakeholders (with 10 to 46 stakeholders identifying each of the reasons listed), included, but were not limited to:

- Multiple changes in governors and commissioners
- The lack of commitment by different commissioners to the implementation of the new children's behavioral health system

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- The short-term vision of some commissioners and leadership staff, when long term sustained vision and leadership is needed to implement culture change
  - The lack of effective decision making skills of several leaders involved in implementing the new system
  - Persistent criticism by the union and providers on all aspects of the new system
  - Lack of an effective state level interagency structure where representatives from all child and serving systems, and key stakeholders, had equal standing
  - Lack of clear policies: "There was never a focus on developing clear policies and protocols, things would change with the wind."
  - Inconsistent oversight of providers: "There is a cadre of providers who provide the bedrock services, such as inpatient, residential, mobile response; these providers are highly regulated. In-home services are uncredentialed, unlicensed and unregulated."
  - Lack of ongoing effective strategic planning
  - Lack of a continuous quality improvement framework for any of the existing oversight structures, that was open to feedback, focused on identifying implementation barriers and developing solutions to the barriers, and using data to assess effectiveness
  - Lack of clear, effective and sustained structures between the state and counties (i.e., areas) that were set up to interface on a regular basis and address ongoing implementation issues
  - Despite the challenges, every stakeholder interviewed shared that the new children's behavioral health system had, and/or has, both strengths and areas to improve. Specific strengths that were identified by multiple stakeholders (i.e., between 10 and 46 stakeholders for each strength listed below) during the interview process, included, but were not limited to:
    - Significantly increase in the number of community-based and in-home services and supports including non-traditional supports (i.e., mentors), to serve children with mental health needs, and their families
    - Successful outcomes, for at least some youth and families served;
    - High satisfaction levels with experiences of services, for at least some youth and families served;
    - Significantly more federal dollars brought in to support children's mental health services in New Jersey
    - Extensive data about the children's behavioral health system now exists that was not available five years ago
    - Use of common screening and assessment tools
    - Families do not have to relinquish custody and enter the child welfare system to access services for their children
    - The focus of services and supports in the new service array (e.g., Care Management Organization (CMO), Mobile Response) is on individualized, flexible, culturally competent and strength-based approaches. This focus is consistent with nationally recognized system of care values, which are considered best practices.



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- Family voice has significantly increased on all levels of care and is meaningful, ranging from representation on numerous state and county/area workgroups, to full engagement in individual treatment and support activities of new child behavioral health system services.
  - A foundation for a system of care for children with mental health needs, and their families, is developed for every area of the state.
  - Statewide implementation, for the first time in New Jersey, of best practices in children's mental health, including use of child and family teams, wraparound services and approaches, focus on family voice, and a range of family support activities
  - Families can access services directly for their children through the CSA
  - Involvement of youth in their own care, and beginning stages of promoting youth partnerships and empowerment"
  - Alternatives to Brisbane are more geographically accessible to all families, and the new programs have clear expectations, such as *no reject* and *short-term treatment*

Specific to governance structure strengths, a number of stakeholders appear to have *confidence* in the new leadership appointed by the Governor to DCF and DCBHS. Some stakeholders shared that the new leadership at DCBHS was more open than previous administrations, and more focused on *accountability*. Others shared that the "governor's business like approach to problem solving, and appointing leadership staff that have that same approach, will help to address many long standing problems with DCBHS." Related to important governance outcomes identified at the beginning of this section, some of the following comments were shared by stakeholders:

- Authority to govern: "The governor gives a strong message about authority with the establishment of the new Department of Children and Families."
- Clear about what it is governing: "Developing new clinical standards, which DCBHS is involved with, will be a great first step towards clarity about what exactly the system of care is."
- Is representative: "The new administration of DCBHS has kept family representatives on the executive committee. This is a good sign." One member of the new administration shared "If we really want to make things better for the children in New Jersey, we need to be sensitive to what is happening on the local level, in the counties."
- Capacity to govern: "Resources are being brought over to DCBHS from the adult mental health system. Time will tell if there are sufficient resources and talented staff."
- Assume shared liability across systems for the target population: "At least this new administration has reached out to other systems in what appears to be a more collaborative manner."

In addition to the above strengths, it must be noted that in interviews with new leadership staff throughout the new Department of Children and Families and DCBHS, those interviewed consistently came across with a strong commitment to "do right by the children and families in New Jersey." Additionally, staff report that they have identified and begun work on a number of areas, including, but not limited to: meeting with key staff in education and

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developmental disabilities; developing clinical standards; reviewing problems with the CSA; understanding the need to improve communication; and identifying priority issues for system improvements, including addressing “the multiple and sometimes confusing levels of care/case management.” These are all areas that were identified by many stakeholders throughout New Jersey as important to address in order to improve the child behavioral health system.

As noted earlier, several issues related to governance were conceptually addressed in the 2000 *Concept Paper* and operationalized, according to some stakeholders, at least to some extent and for some periods of time on the state level (e.g., “spelling out what the new services would look like,” “emphasizing family involvement,” “creating oversight bodies”) since the 2000 reform initiative began. Despite the belief by some stakeholders that at least a few of the governance areas were addressed in design and/or implementation, what came across loud and clear from stakeholder interviews is that if the newly created ‘system of care’ had been a newly developed product that a company was intending to sell, that “the leadership team, the marketing department and the advertising agency failed to sell the new project to many stakeholders.” Stakeholder voices throughout New Jersey have enumerated problems with New Jersey’s ‘new product’ and have shared their belief that their concerns “were largely not heard and not adequately addressed.”

Several stakeholders stressed that the 2000 *Concept Paper* actually built on reforms that had been in development throughout the 1990’s. In fact, a few stakeholders who were interviewed expressed preference for these earlier reform efforts (e.g., establishment of the Children’s/County Interagency Coordinating Council (CIACC) and the Case Assessment Resource Teams (CART)) because they were “locally based” and provided stakeholders within different locales “flexibility and ownership.” Additionally, the CARTs involved cross agency funding on the local level “with initial monies from developmental disabilities and ongoing funding from county run Youth Incentive Programs, which included wraparound services.” On the other hand, it was also acknowledged that the CARTs and CIACCs were not fully implemented in every county and that implementation efforts met with varying degrees of success in different counties.

It is clear that the mental health system for children in New Jersey has been undergoing change for at least 17 years, with many of the changes appearing to be implemented by “well intentioned leaders on the State level.” It is also clear that many, if not most, of the changes implemented have been consistent with best practice system of care values for children’s mental health (e.g., CIACCs and CARTs promoted cross systems care; FSO’s promote family support activities; CMO’s promote child and family teams, which focus on individualized, flexible, and culturally sensitive care). Additionally, resources dedicated to child mental health have been growing. It was reported by stakeholders that “in the early 1980’s the State had only one state level position dedicated to children’s services,” now it has an entire Division. Another stakeholder reported that... “in 1989, only 15,000 children received state sponsored mental health services statewide,” with 32,081 receiving specific DCBHS services in April 2006 (DCBHS Agency Summary, Report NJ0232.1).



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It must be recognized that systems of care are ever evolving and New Jersey has only in the past five years, begun a journey towards implementing statewide systems of care. New Jersey should be acknowledged as one of only a few states in the country that have developed and implemented a statewide foundation of core services, which operationalize best practice system of care values. The new State leadership should recognize the many strengths of the system and honor the many accomplishments that New Jersey stakeholders of children's mental health have made over the past nearly 20 years. A number of stakeholders expressed serious concerns that the new administration would not "understand the need to keep and continue to improve upon the many current strengths of the system," and would, in fact, "throw out everything."

Despite the overall positive trajectory, without significant improvements in the governance structures on the State and local levels, child behavioral health care in New Jersey is at risk for losing ground. Without committed, sustained and effective state level leadership and governance structures, the "disenchantment with the system," the "feelings of disempowerment," and the "chaos that has taken over the system" could serve to slowly dismantle some of the gains made. One of the most important tasks at this juncture in the development of the New Jersey system of care is to strengthen the governance structures at the state and local levels.

## Recommendations

Stakeholders interviewed outlined numerous and varied improvements needed to improve State level governance. The recommendations most often cited by stakeholders specific to or relating to state governance structure included:

- Committed, effective and sustained leadership at the commissioner and director levels
- Develop and regularly utilize effective communication strategies
- Clear protocols and policies, as opposed to "ever changing directives provided in numerous ways (e.g., shared at meetings, through letters and emails)"
- An effective state level interagency structure where representatives from all child and serving systems, and key stakeholders, have equal standing
- Development of clear and unduplicated structures at the county/area level that have authority and oversee child mental health services at the county/area level
- Leadership positions at the county/area level that are responsible for the implementation of a system of care, and interface with all system partners
- All system partners committed to and actively involved in the children's behavioral health system of care (e.g., Developmental Disabilities, Education, Juvenile Justice)
- Affiliation agreements that are meaningful; DCHBS has some that are still in draft
- A process for ongoing engagement and involvement of stakeholders in all aspects of the system of care
- Regular access to useful data

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- Flexibility within the system, especially related to allowing counties to respond to the unique needs of their areas and related to specialized needs of discrete populations
  - Clear, effective and sustained structures between the State and the 15 service areas to interface on a regular basis and address ongoing implementation issues

## System of Care Development

In addition to struggling with the above noted governance issues, the children's behavioral health system is experiencing challenges in operationalizing the values, philosophy, and principles of systems of care. The *Children's Initiative Concept Paper* (State of New Jersey, 2000) originally conceptualized the reform as one, "designed to break down barriers between child-serving systems. It is not a Mental health Initiative; not a DYFS Initiative, not a Medicaid Initiative; not a Juvenile Justice Initiative. It is a Children's Initiative and addresses the whole child in all aspects of family and community life, focusing on strengths that support community living and healthy social development for children and families" (Children's Initiative Concept Paper, [State of New Jersey, 2000, p. 8]). This challenge of collaboration and operationalizing a common set of values, principles and philosophy across publicly funded departments is daunting and it is not surprising that this goal is difficult to achieve.

State and county child-serving entities certainly must attend to their respective missions (e.g., mental health, education, juvenile justice, child welfare and developmental disabilities). However, children in need of mental health and behavioral health services, especially those with the most complicated needs, 'reside' in each system and often in multiple systems. This makes the development of policies, procedures, funding streams and service arrays across these domains key to serving these children and youth and their families, as articulated in the reform plan. As one participant of the Judiciary focus group noted, "If you look at juvenile justice on one hand and child welfare issues on the other hand, it is kind of a bell-shaped curve. I would suggest that you can imagine on one end of this curve, the Juvenile Justice Commission which deals with the deeper-end kids with the more serious delinquent involvement. The other end of that bell-shaped curve would be those children with purely mental health issues that don't come before the court at all...there is a bump here in the middle somewhere, where you see kids who have aspects of both. And one of the fallacies...that we are entertaining all the time is that there's a bright line that distinguishes these children one from the other...And, that's not true...we need to get away from the perpetration of this fiction, that...there's one system that recognizes clearly the need to intervene and the other systems back off. What we need are partnerships between these systems."

Insight into the perceived level of commitment of system partners to the system of care (SOC) philosophy, values, and principles is provided in findings from the web survey on responses to the question: "This system partner is committed to system of care philosophy, values and principles" (see **Table 4**). For example, 61% Strongly Agreed (59% Agreed) that CMOs are committed to System of care philosophy, values, and principles while 0% Strongly Agreed that Education or Developmental Disabilities were committed to system of care philosophy, values and principles.

<b>Table 4.</b> <b>Percent of Respondents by Level of Agreement that System Partners</b> <b>are Committed to the System of Care Philosophy, Values, and Principles (N=91)</b>						
	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Not an SOC Partner
Education	0% (0)	20% (18)	30% (27)	17% (15)	21% (19)	12% (11)
Child Welfare/DYFS	8% (7)	49% (26)	41% (37)	18% (16)	4% (4)	1% (1)
Juvenile Justice	2% (2)	34% (31)	39% (35)	9% (8)	16% (14)	0% (0)
Developmental Disabilities	0% (0)	9% (8)	24% (22)	12% (11)	30% (27)	24% (22)
DCBHS	37% (32)	43% (37)	11% (10)	5% (4)	5% (4)	0% (0)
MRSS	44% (39)	40% (35)	7% (6)	0% (0)	9% (8)	0% (0)
CMO	61% (54)	31% (28)	6% (5)	1% (1)	1% (1)	0% (0)
YCM	27% (24)	52% (46)	13% (12)	2% (2)	6% (5)	0% (0)
CSA	16% (14)	40% (36)	22% (20)	13% (12)	9% (8)	0% (0)
Residential Service Providers	4% (4)	19% (17)	37% (33)	12% (11)	26% (23)	1% (1)
Outpatient Service Providers	4% (4)	32% (29)	31% (29)	8% (7)	19% (17)	7% (6)
In-home Service Providers	11% (10)	54% (49)	13% (12)	2% (2)	18% (16)	1% (1)

Overall, 50% or more of the 91 respondents to this question either Strongly Agreed or Agreed that the following entities were committed to System of care philosophy, values, and principles:

- CMO (92%)
- MRSS (84%)
- DCBHS (80%)
- YCM (79%)
- In-Home Service Providers (65%)
- CSA (56%)

These data are consistent with comments from the Judiciary focus group regarding education, developmental disabilities, and substance abuse services falling outside the partnership of agencies engaged with the system of care initiative. Overall, the data indicate the children's behavioral health system of care is developing with strong perceived commitment to systems of care by children's mental health providers and service entities at the County level and by DCBHS and the CSA at the State level (although to a lesser degree for the CSA). This likely speaks to the training initiatives and the collaborative work that has occurred among these groups in the past few years as they have built this new service system.

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It is understandable that more work needs to be done to bring the other publicly funded system partners and private providers to the table around system of care goals and philosophy. Commitment was notably weaker for these broader system partners and for traditional providers (e.g., Education, Developmental Disabilities, Juvenile Justice, Residential Service Providers, and Outpatient Providers). More education regarding these values and principles, joint decision-making and the development of linking protocols are likely required. For example, data from a separate survey of the defense attorneys and the law guardians indicated that in general, they “did not know” which entities were committed to SOC values and principles except for in-home service providers, highlighting the likely need for education and interaction. The need to promote stronger ties with education, developmental disabilities, and substance abuse services was noted in focus groups as well as in the web survey findings.

It should be noted that the FSO structure was inadvertently omitted from the rating options, but in an open-ended follow-up question in the web survey, respondents had the opportunity to list system partners not included in the list and to indicate whether these entities agreed or disagreed with SOC philosophy, values, and principles. Ten of the 22 respondents who used the follow-up question cited the FSOs as partners with eight of ten indicating that they strongly agreed that the FSOs were committed to these values and principles.

Other entities listed as “system partners” in the open-ended question included acute inpatient care, psychiatrists, substance abuse service providers, county social services, partial care providers, county work force investment boards, and county human services organizations. Those respondents who commented about these partners’ commitment to system of care ways of work perceived that these entities disagreed with SOC values, philosophy and principles or that there was a lack of knowledge of SOC ways of doing business. Leadership at the state level will be required to bring these systems to the table in a meaningful way and as noted in the *Children’s Initiative Concept Paper* (State of New Jersey, 2000), to “Establish the organizational structure for ongoing collaborative planning and system management among all child-serving systems to assure effective integration of policy, resources, and procedures to support an organized system of care for children and families” (p. 5).

In addition, to leadership at the state level to bring partners together, there also is a need for DCBHS and Value Options to partner at the local level in operationalizing SOC values, philosophy, and principles. With respect to the impact of vertical integration on the implementation of SOC values, philosophy, and principles at the county level, one web survey respondent articulated the issues by commenting that, “The problem is not that people are ‘uncommitted’ to the philosophy. The problem is that the state is attempting to carry out a ‘system of care’ without local system involvement. The state (DCBHS at this point) has not acknowledged — or is not aware — that county governments and other entities provide much of the funding for local services and there must be coordination. We have to plan and make decisions together.” True collaboration and operationalizing values, philosophies, and principles that represent a significant paradigm shift require persistence and commitment by

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all parties to new ways of work. While the *news* is mixed regarding the commitment to values, philosophy, and principles of SOC, a great deal of work has been done and the foundation is there to build upon in the next iteration of the system reform effort.

## **Interagency Collaboration at State and Local Levels**

In addition to the needs related to improving State level governance, many stakeholders expressed concerns specific to interagency collaboration. Collaboration among system and community partners at the state and local level is crucial in any system reform effort and the New Jersey children's behavioral health system is no exception. Collaboration best practices (Mattessich, Murray-Close, & Monsey, 2001) indicate that strong and effective collaboration requires trust, respect, representation, commitment, openness to new ways of work, clear sense of roles and responsibilities, the ability to adapt, the resources to engage in coordination activities, knowledge and understanding of goals, and in a system of care environment, family inclusion, family voice and choice.

Specific to the concerns about child welfare taking "priority over everything," many stakeholders expressed belief that the leadership at DYFS was "only concerned about fixing child welfare" and that the "seemingly singular focus on child welfare reform activities by State leadership staff" in the Department of Human Services (DHS) and the Division of Child Behavioral Health Services (DCBHS) over the past several years, and "the multiple changes in State leadership on all levels," "redirected State child behavioral staff attention away from careful development of the new children's behavioral health system." A senior State level behavioral health staff from another State shared that when their "own State child mental health authority was under the auspices of child welfare, nothing moved forward; all focus was on child welfare; since child mental health has been moved under adult mental health, the statewide focus on stigma and recovery and consumer involvement gave a boost to a parallel focus on child mental health."

Within New Jersey's block grant application, reference was made to collaborative efforts between mental health and education, and also to the Child Behavioral Health Services System Implementation Advisory Committee:

**"As the statewide Child Behavioral Health Services System unfolds, the Statewide Implementation Advisory Committee has assumed the leadership role formerly filled by the Children's Coordinating Council. This 40-person group meets monthly to provide input on the implementation of the initiative and to assist the Department of Human Services (DHS) in developing strategies to ensure the reform goals will be met."**

Over 18 months after this was written, nearly every governance level stakeholder interviewed about this workgroup stressed that "it never worked effectively." Stakeholders shared that the workgroup was "never truly an interagency body working together." A number of stakeholders representing different State agencies shared "I never felt as if I really had a meaningful voice," "it was a group dedicated to telling the rest of us what was going on, not asking for our input; if our input was asked for, it never seemed to result in anything." There

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was not a feeling of animosity from the stakeholders interviewed, just a sharing that the interagency group was “not effective.” Stakeholders shared that “the group stopped meeting in November 2005.”

In addition to concerns raised about the lack of an effective State level interagency workgroup, nearly every stakeholder who responded to questions about interface with the Department of Education shared that there had “not been a formal and meaningful interface to date.” Acknowledgements were made that “there are some unique collaborations with mental health and school districts on the local level” and “in some districts, CMOs, FSOs and schools have developed partnerships.” Despite this collaborative work in some locales, not one stakeholder interviewed shared positives about outcomes achieved statewide stemming from collaboration with the Department of Education. In fact, stakeholders shared “from the start schools were not at the table; they were not considered a partner; they were not even on the diagram.” It also was acknowledged that “with over 600 school districts and 700 charter schools it is difficult to get a single message across” and “communication has improved recently, with some task forces looking at real issues.”

Finally, related to interagency collaboration, several stakeholders report that only in the past year has formal work begun with the State Department of Developmental Disabilities (DDD) to bring DDD into the system of care for children with mental health needs. One stakeholder shared DDD has “not ever been involved in a formal way with DCBHS and is just beginning to work out individual agreements.” Despite this perception by many stakeholders, one stakeholder shared that “in the early stages of the system of care initiative, a specialized version of the CANS was developed for children with developmental disabilities” and another shared, “last year Value Options assessed their protocols to see if they fit with developmental disability needs.”

Most stakeholders report that true interagency collaboration with all child and family serving partners on the State, regional or county/area has not occurred on a planned, consistent and/or formal basis. Although a number of stakeholders acknowledge that the 2000 reform efforts included a strong intent to achieve this collaboration, and a number of State level, regional level and county/area structures were put into place towards achieving this goal, they were not successfully implemented statewide. There appear to be “islands of excellence.” A number of stakeholders referred to “the success of Burlington County in setting up a successful cross system structure” and others referred to “successful regional councils in the north and south regions” of the State. Not one stakeholder shared that there was an effective interagency State level governance structure in New Jersey.

The web-based survey results regarding interagency collaboration indicate that there are a number of strengths in line with these best practices at the county level. The results indicate that the stakeholders perceive notable collaboration strengths (60% or more either Strongly Agree or Agree) in areas such as respect (81%), cross sectional representation of stakeholders (71%), seeing benefits to their organizations in being involved in the collaboration (82%), level of commitment of partners (74%), clarity of understanding of what the collaborative effort



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is trying to accomplish (75%), and voices of family members and consumers reflected in the collaboration (62%). Work remains to be done in areas related to trust (30%), clarity of roles and responsibilities (53%), and ability to adapt to changing conditions (52%).

Survey respondents (n = 69) also indicate strong collaborative efforts between specific service partners and system components as indicated in Table B: Ratings of Collaboration between Service and System Partners. Ratings in Bold in Table B indicate strong collaboration (On average 60% or more rated the collaboration as going Very Well or Well). For example, the CSA and MRSS were viewed on average as working Very Well or Well together by 69% of the respondents; CMOs and FSOs were viewed as working Very Well or Well together by 81% of the respondents; and so on. Areas of strength included the following pairings:

- CSA and MRSS
- CMO with YCM, MRSS, FSO, Other Service Providers, Community Stakeholders, Consumers
- YCM with CMO, MRSS, Service Providers, Other Agencies, Community Stakeholders and Consumers
- MRSS with all Categories (CSA, CMO, YCM, FSO, DCBHS, Service Providers, Other Agencies, Community Stakeholders, and Consumers)
- FSO with CMO, MRSS, DCBHS, Other Agencies, Community Stakeholders, Consumers

These positive perceptions of collaboration provide a strong base for effective partnerships needed to improve the total service system over time. It is important to note that the levels of collaboration varied greatly across counties. Areas of development include the need to improve collaboration between CMO, YCM, FSO with the CSA, as well as the collaboration between CMO and DCBHS and YCM and DCBHS. These collaboration “pairings” may require greater effort, formal linkages, and clear communication strategies since they involve communication and collaboration between different levels of the system (e.g., between state level and county partners).

The ratings between FSO and CSA, and between FSO and YCM, and FSO and Service Providers, while lower than 60%, may be appropriate given the mandate of the FSOs. Also, it should be noted that respondents were provided with the option of “Not Designed to Collaborate” and that 12% of respondents chose this rating when queried about the FSO and YCM collaborative relationship. This may be related to the fact that children, youth, and the families served by the YCM do not have access to FSO supports other than family support groups in the community.

<b>Table 5.</b> <b>Percentage Ratings of Collaboration between Service and System Partners (N=68)</b>					
	<b>CSA</b>	<b>CMO</b>	<b>YCM</b>	<b>MRSS</b>	<b>FSO</b>
<b>CSA</b>	NA*	48	43	69	58
<b>CMO</b>	48	NA	71	68	81
<b>YCM</b>	43	71	NA	76	39
<b>MRSS</b>	69	68	76	NA	68
<b>FSO</b>	58	81	39	68	NA
<b>DCBHS</b>	NA	58	53	73	72
<b>Service Providers</b>	NA	72	66	86	57
<b>Other Agencies (e.g., CW, JJ)</b>	NA	51	63	70	63
<b>Community Stakeholders</b>	NA	71	67	85	71
<b>Consumers</b>	NA	74	88	93	82
* NA = Not Asked					
Bold = More than 60% of Respondents indicated that Organizations/Partners Collaborate Very Well or Well					

In summary, the overall service system design reflects best practices and has the potential to provide the timely, appropriate, effective services that are individualized, least restrictive, and with strong family engagement. In addition, perceptions of collaboration, particularly at the county level, were positive especially given the fact that implementation is still in the early stages for some counties and given the fact that much of the implementation has taken place in the context of many changes at the state level. The collaborative base is developing and should be recognized, sustained, and utilized as systems improvement strategies are developed and implemented.



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## Local Level Governance Structure

“You really can’t separate success of the system of care from the context in New Jersey in the last five years, it is wild, it is just like the most amazing place, there is different leadership in government, not just the governors, but the commissioners and directors that have been in and out of those offices so many times, the federal lawsuit on the child welfare thing which created a kind of reign of terror for DYFS, the lawsuits on the Juvenile Justice System where some of our kids were involved, so the context has been hysteria on occasion and just trying to get your voice heard in that environment has been a real challenge.” CMO Director.

## Current Status/Background

“Effective systems of care require a strong collaborative relationship to be built between state and local stakeholders to clarify and address the ways in which state policies and practices can be strengthened and aligned to support local systems of care” (p. 12). As noted by Pires (2002), “A partnership between state and local stakeholders is needed to ensure that system partners at both levels view themselves as the same system- building team” (p. 12 ). If we consider again the definitions of governance as described at the beginning of Governance Structure assessment, it is clear that New Jersey’s children’s behavioral health system does not have a governance structure at the local level. Since a local governance structure in the truest form does not exist, the remainder of this section will focus on the findings regarding structures in place at the local level that have the potential to provide local oversight and accountability for the local children’s behavioral health system, the role of Team Leaders as liaisons between the state and local level, and communication processes between the state and local levels.

## Findings

When asked to describe the local governance structure, focus group and survey participants named several boards, councils, committees and meetings that were currently operating in their counties including: Children’s Interagency Coordinating Councils (CIACC), Case Assessment Resource Teams (CART), Selection Review/Teams, Implementation Teams, Systems Review Committee, “Fix It” Meetings, Youth Services Commission, Professional Advisory Committee, County Mental Health Boards, Human Services Advisory Council, Juvenile/ Detention Review, QSR Leadership Committee, and Substance Abuse Committee. This list is not exhaustive; multiple variations of these boards/councils/committees exist. However, focus group participants were quick to point out that these boards, councils, committees and meetings did not constitute a local governance structure because there was not a true governing body at the local level. Reportedly, all governance related decisions about the local children’s behavioral health system occurred at the state level and local entities only served in an advisory capacity to state level governance. Therefore the above referenced boards, councils, committees and meetings were in place to primarily address the operational issues (e.g., coordination of Intensive In-home Care (IIC) providers and Behavioral Assistants (BA), or system management issues, at the local level.

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## Overview of Local Boards, Councils, and Committees

At the local level, counties have multiple boards/committees/councils attending to children's behavioral health. While in most counties the same types of boards exist, the names and actual functions and responsibilities differ greatly from county to county (or vicinage to vicinage). Several types of boards appear to be more standardized (such as the CIACC); however, there are several ad hoc boards/council/committees that have been created for problem-solving and/or to handle issues/relationships among system partners.

When prompted for detail regarding the purposes and participants of the various types of boards/councils/committees/meetings, focus group participants indicated that the mission, goals, purpose and participants often overlapped across these entities and that this had both negative and positive implications for the community depending on locale. For example, participants were concerned about the attendance of specific groups/representatives on some boards as it presented opportunities for conflicts of interest. On the other hand, the overlap provided for some redundancy across boards/councils/committees which would allow issues/topics to surface in more than one place thus increasing the likelihood that the issue would be addressed. This mix in response was also seen in the survey data. Fifty-six percent of respondents strongly agreed or agreed that the mission, goals and outcomes across entities was duplicative; 80% strongly agreed or agreed that the same participants were serving on multiple boards, councils, committees. When asked if having the same persons serve on multiple boards was a positive practice, 28% of respondents expressed a neutral opinion, 32% strongly agreed or agreed and 36% disagreed or strongly disagreed.

<b>Table 6.</b> <b>Functions of Local Boards</b>							
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know	Response Total
The missions, goals and outcomes across boards, committees and councils are duplicative (overlap).	17% (15)	39% (34)	16% (14)	14% (12)	5% (4)	9% (3)	87
Many of the same people serve on multiple boards, committees and councils.	33% (29)	47% (41)	7% (6)	1% (1)	0% (0)	11% (10)	87
Having the same people serve on multiple boards, committees and councils is a positive practice..	6% (5)	26% (22)	28% (24)	26% (22)	10% (9)	5% (4)	86

Table 6. Functions of Local Boards							Continued
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know	Response Total
Having the same people serve on multiple boards, committees and councils is a negative practice.	7% (6)	24% (21)	28% (24)	29% (25)	7% (6)	6% (5)	87

Survey participants also were given an opportunity to respond to a set of questions regarding interaction among boards, councils and committees as well as methods/procedures for communication and effectiveness at solving service delivery problems. The data indicate a system that is somewhat weak with regard to facilitating communication among stakeholders. Forty-one percent of respondents strongly agreed or agreed that the boards, councils and committees interacted with one another in an organized way that included joint meetings and report sharing. In regard to effective methods and procedures for communication with system partners, one-third of respondents strongly agreed or agreed that the methods and procedures were effective while 41% disagreed or strongly disagreed. When asked about communication with stakeholders and consumers, 36% strongly agreed or agreed that the methods and procedures were effective while 41% disagreed or strongly disagreed. Thus, it appears that the boards, councils, committees at the local level are slightly more successful at communicating and interacting with one another than they are in communicating with system partners and community stakeholders. Communication of information to the community may not be seen as a function of the local boards, councils, committees but more of a function of the Team Leader, often an attendee (or required participant) of local meetings, as the system communication liaison (see Team Leader section below).

### Board Influence and Authority

About half of focus group and survey participants (49%) agreed that the board/council with the most influence on the children's behavioral health system at the local level was the Children's/County Interagency Coordinating Council (CIACC). CIACCs began as CARTS, almost 20 years ago, when CARTS were implemented at the county level. From focus group discussions with YCM, CMO, FSO and MRSS participants, CIACCs are described as public meetings that bring to together representatives from all child serving entities in a community and serve as a planning and decision making body at the local level. The CIACC is typically convened by the county mental health administrator and can have upwards of 30 representatives attending depending on locale. However, since the CIACCs predate the children's behavioral health system, focus group participants noted that not all CIACC members have bought into the values and principles of a system of care, which, at times, has made decision making difficult. Focus group participants attributed the following responsibilities to CIACCs: conduct local service needs assessments, provide access to a limited amount of county resource dollars for special

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programming, obtain grant funding for programs to address needs in the community, cover costs associated with convening meetings, and oversee the distribution of flex funds among the CSA, MRSS, and YCM.

While the actual influence held by the CIACC was considered to be variable across counties, focus group participants stressed that the CIACC was advisory only and did not have any authority to make or enforce changes at the local level. This theme was supported by survey data: half of respondents disagreed or strongly disagreed that, overall, the boards/councils/committees at the local level had the appropriate degree of authority to carry out their mission and goals. In addition, 33% of survey respondents indicated a neutral (no opinion) on whether boards should have more authority while 35% strongly agreed or agreed; 46% disagreed or strongly disagreed when asked if the boards should have less authority. In all, survey participants felt that the current level of authority given to local boards, councils and committees was not appropriate and that more governance authority should be granted to these entities.

## Local System Interaction with State Level Governance

### Team Leaders

Team Leaders serve as the connection between the state and local systems. The role of the Team Leader is quite extensive and, as can be seen from **Table 7**, the role description of the Team Leader is vague and open to interpretation.

<b>Table 7.</b> <b>Team Leader's Operational Duties</b>	
<b>Category</b>	<b>Detail</b>
Develop, implement and monitor children's system of care for children with emotional behavioral disorders.	1. Provide technical assistance on data collection. Meets with providers as requested/required to educate about process.
	2. Reviews data from CSA and local providers and interprets with community and division.
	3. Staff Selection, Implementation and Systems Review committee to ensure compliance.
	4. Provides information/feedback to DCBHS
Data Review and Synthesis	1. Reviews CSA reports—ISP Cycle Time, Overdue Service Plans, ISP Tracking Report, CMO Performance Summary, CMO Demographic Error Details.
	2. Review QSR data and reports. Develops follow up report with CQI.
	3. Reviews data/QCMR for annual contract renewals.

<b>Table 7.</b> <span style="float: right;">Continued</span> <b>Team Leader's Operational Duties</b>	
<b>Category</b>	<b>Detail</b>
Fiscal	1. With contract administrator reviews all children's programs for level of service for renewals.
	2. Assists community agencies in monitoring BA/IIC/
	3. Assists CIACC in monitoring wrap flex funds.
	4. Tracks all funding issues and identifies shortages and follows up with DCBHS staff.
	5. Develops general knowledge of contract related issues and reports.
Planning	1. Identifies needs and gaps in all elements of the local area system for DCBHS.
	2. Identifies all operational issues that relate to policy and procedure developed by DCBHS in the community.
	3. With local planning bodies (YSAC/HSAC/MHB/CEAS/CIACC) identifies needs that effect all DCBHS children across systems and develop local solutions where applicable.
Constituency Relations	1. Answer all inquires from external sources (Governor's Office/ Commissioner's Office/Families) which includes investigations with community agencies.
	2. Works with families in the grievance process and complaints before using the formal procedure.
	3. Answers all questions/Inquires from DCBHS about the local community agencies, practices, etc.
	4. Provides community education to all community programs and system partners requesting information.
Quality Assurance/CQI	1. Works with CQI on QSR and provides follow up
	2. Attends all site reviews in their areas with OOL.
	3. Follows up on site review issues as requested.
	4. Participates with OOL and CQI on focused site reviews as requested.

<b>Table 7.</b> <b>Team Leader's Operational Duties</b>		Continued
Category	Detail	
Knowledge Base	1. All DCBHS policy and procedure and operationalize for community agencies and constituents. CMO, MRSS, FSO, YCM, Youth partnership, Partial Care, Outpatient, Screening, CCIS, Out of Home Placements.	
	2. Protocols for all dual management of families including DYFS, JJC, Educations, D&A, etc.	
	3. Value Options policy and procedures and operationalize for community and constituents.	
	4. Clinical profiles and general clinical theory and practice. participates in case conferencing.	
Responsibilities	1. Assures programs are at 95% capacity.	
	2. Assures programs complete required reports—monthly out of home/discharge ready reports.	
	3. Assures monthly meetings are convened to discuss out of state youth, discharge ready youth, and youth in detention for the purpose of discharge planning.	
	4. Provides monthly report to DCBHS to provide status and necessary updates about their area.	

The overarching role of the Team Leader, as described by Team Leaders and by CMO, YCM, FSO, and MRSS focus group participants, is to serve as a liaison and communication link between the local children's behavioral health system partners and DCBHS. The one clear function of the Team Leader, as shared by participants, is to share information from the local level with the state level governance and to bring information from the state level back down to the counties/vicinages. However, focus group participants listed several other roles and responsibilities including: case manager for high profile cases, overall-systems problem solver, 24/7 on call assistance, the voice of the local system partners, and information disseminator. Team Leaders, during their focus group, added that their role was really about community development, which is a much broader role than a liaison. Focus group participants used terms such as "nebulous" and "fluid" to describe the work of the Team Leaders. Team Leaders spoke of having to be "responsible for everything" and of being overwhelmed with the number of tasks. As just one example, one Team Leader shared with the interviewers a list of over 30 meetings that he had to attend every month. In addition, the exact "area" that becomes the Team Leader's responsibility may encompass one county or up to three. For example, one vicinage had a CIACC in all three counties and an overarching CIACC to connect the individual county CIACCs. The Team Leader would thus be responsible for attending and getting information from all four of the CIACCs.

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Survey participants also were given opportunities to respond to questions pertaining to the Team Leader role and value to the children's behavioral health system. About half of respondents strongly agreed or agreed that the Team Leader's role as a liaison was beneficial to the children's behavioral health system. In addition, respondents were able to indicate which roles the Team Leader(s) had played in their community and if those roles were appropriate for a Team Leader. Case management, 24/7 on-call assistance and contract management were seen as inappropriate roles for Team Leaders. It should be noted that the YCM focus group participants were much more positive about the Team Leader serving as case manager and providing 24/7 assistance and a limited number of YCM participants responded to the survey. Thus, what is deemed as an appropriate role for a Team Leader may be solely determined based the needs of the particular behavioral health system partner. Due to the extensive and sometimes vague list of functions and responsibilities of Team Leaders, it is difficult for all involved, especially the Team Leaders, to define what are appropriate versus inappropriate tasks.

In regard to the effectiveness of the Team Leader, YCM, MRSS, CMO, FSO, and County Mental Health Administrator participants had mixed responses. For many, the Team Leader position was considered to be very valuable and an effective means for problem solving and increasing system functionality. However, others felt that the Team Leader role was ineffective and that Team Leaders did not positively impact the children's behavioral health system. Given that the functions of a Team Leader are currently focused on the needs of specific system partners, rather than those of the overall local system, this mix in response seems reasonable. Focus group participants stressed that there is great variability in Team Leader skill and effectiveness; and noted that Team Leader effectiveness is highly dependent upon the individual characteristics of the Team Leader and the stage of development of the local system (with newer systems necessitating more of the community development skills the Team Leaders mentioned). The Team Leader position also is prone to high turnover rates making it difficult for system partners to build trust and a relationship with a Team Leader. One YCM participant mentioned having five different Team Leaders in a period of five years. Focus group participants were quick to note, however, that due to the changing nature of the local systems, Team Leaders must be flexible to accommodate county needs and "county flavor."

## **Communication**

Focus group participants were clear that while information from the local level (provided by boards and individual system partners) was given to the Team Leaders to share at the state level, it is not necessarily known with whom the Team Leader shared the information or the chain of communication above the Team Leader. The majority also agreed that it is very unlikely that information would come back down through the Team Leader or that action would be taken at the state level to address issues. County Mental Health Administrator focus group participants felt that the communication was much clearer and more effective when the CIACC conveners had a single point of contact with a central person and that CIACC members successfully performed many of the Team Leader functions prior to the installation of the Team Leader in the counties.



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Survey participants also were asked to respond to questions relating to changes that had taken place in the community as a result of board recommendations and/or information presented to DCBHS. About one-third of respondents indicated that it was 'only rarely' that change would be seen in the community as a result of board recommendations.

Three themes regarding communication processes between the local level and the state were discussed by focus group participants: (1) formats and methods through which system partners received information from DCBHS, (2) lack of alignment or vertical integration at the state, local and practice levels, and (3) lack of local level system inclusion in policy development and implementation.

In regard to communication formats and methods, both focus group and survey respondents expressed frustration over the lack of finalized written policies from the state to the local level. Policies and information, if received in writing at all, were often in "draft" form with a finalized version never completed. Participants and respondents pointed out that finalized written policies and procedures were never created because there had been constant change in the system and that information communicated from the state was variable from one day to the next (relevant one day and obsolete the next). Or, as shared by a CMO participant, a policy would be mandated only to be followed by "...14 waivers and 62 work-arounds; always exceptions..." which led to inconsistencies from the start. As summarized by one survey respondent: "Everything at this point (at the 5 year mark) is fluid, moveable, and non-permanent."

Evaluation participants also expressed concerns over how information was disseminated from DCBHS to the local level. Both focus group and survey participants indicated multiple avenues and contexts for receiving information, which included the local CIACC, Team Leaders, email (most often cited), regular mail, information left on tables after meetings, word of mouth, and verbal communication. While some participants did find that information was received on a regular basis, many described the receipt of communication and information as being unpredictable "days after they implement it," and, at times, not at all useful. Fifty-six percent of survey respondents strongly disagreed or disagreed that DCBHS has effective procedures in place for communicating with the boards at the local level. In addition, 55% strongly disagreed or disagreed that the DCBHS could effectively assist boards in solving service delivery problem.

A second theme regarding communication was the lack of alignment, or vertical integration, between the state, local and practice levels, which negatively impacted communication processes. Participants stressed that a missing piece was a clear understanding of the functions needed to support the implementation of the children's behavioral health system (such as accountability functions) and an understanding of how those functions would be accomplished at each level of the system. CMO focus group participants had consensus that the principles, values, concepts and functions of a system of care model were not agreed upon by all the system partners and operationalized differently (or not at all) from organization to organization and from system level to system level. In essence, practice, local and state level silos have been



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created (as well as silos for DYFS and JJ), each with its own interpretation of the children's behavioral health system functions and ways of work. The silos have created a burden on communication across system levels.

The third overall communication theme expressed by focus group participants was that of local level exclusion in the development of policies and procedures. Over and over participants stressed the lack of local level system partners, input in the development of policies and procedures for the overall children's behavioral health system. As mentioned previously, mandated policy changes from the state level are often not applicable or unable to be implemented because they do not correspond with policies and procedures already in use at the local level or do not take into account the needs at the local level. Focus group participants also expressed frustration regarding the lack of opportunities, formal or otherwise, available to express their concerns and issues to the DCBHS. Both focus group participants and survey respondents agreed that requests for information from the DCBHS did not occur often with, 33.7% of survey respondents indicating that "sometimes" the DCBHS requests information from local boards.

## Strengths

As opposed to having too few system partners and community members involved, which can be a problem for some system of care efforts, New Jersey has an abundance of individuals, organizations, and entities that are involved in the children's behavioral health system. As noted above, it appears that counties/vicinages have a multitude of boards, councils, meetings, and committees all working to improve the system for children and families. While the functions and participants may overlap across the boards, councils, etc., system partners at the local level have a plethora of avenues at their disposal for resolving issues and increasing their capacity to effectively serve children and families. Systems partners appear very adept at problem solving and working within the constraints and boundaries of the current system while actively working to effect change within the system. An enormous amount of knowledge is contained within the local systems and that knowledge should be harnessed, disseminated across the system, and utilized by other system partners where appropriate.

One avenue for problem solving and information dissemination that seems to be having an impact for local system partners is that of emerging communities of practices. Communities<sup>1</sup> of practice are groups of professionals who share a common set of goals, interests, practices, and problems, who pursue common solutions and, who embody significant practice and systems knowledge. The MRSS, CMO Directors, and FSO Directors have developed (MRSS and CMO), or are in the process of developing (FSO), communities of practice that enable them to problem solve, reach consensus on issues, and present issues to the DCBHS as one voice. The MRSS Directors were quite pleased with the development of their community of practice and felt that the group would be better able to address the development of the MRSS and allow them to have a united, solid voice in the system. Building

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1 Love & Wenger (1991) coined the phrase, ov Wenger (1998).

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and supporting communities of practices at the local and state levels can serve to empower system partners and enhance the knowledge base of the entire system. In addition, they can become logical points for proactive state level communication (e.g., input into policy development) as well as ‘listening posts’ for state level decision makers within DCBHS as the intended and unintended impact of policies and procedures reverberate in the system structures.

## **Recommendations Regarding Local Governance**

Effective local interagency governance structures and problem solving mechanisms need to be developed and fully implemented. New Jersey is faced with the unique challenge of building a system of care for children with mental health needs, and their families, at the local level – without the benefit of a single mental health authority at the local level to oversee implementation and ensure accountability of the system. Although it is beyond the parameters of this report to recommend establishing any one type of single mental health authority at the local level (i.e., County Mental Health Authorities), which would require statutory changes, DCF and DCBHS must find a means to ensure clear and respected authoritative oversight and accountability at the local level.

New Jersey is not alone with this challenge, as other States also lack a singular local mental health authority. It is recommended that DCF and DCBHS create a workgroup that includes county and state government and other stakeholder representatives, including family members, to study the issues related to achieving county/local oversight and accountability of local/county child behavioral health systems. The workgroup should consider a number of areas in strengthening local oversight and accountability. Ideas include, but are not limited to:

- Review and assess needs related to both regional and county/local oversight. Many States utilize both regional and local models; contact other States and assess both the perceived effectiveness of regional and local models, as well as staffing needs.
- Contact other State mental health authorities that do not have formal County Mental Health Authorities to learn about how they ensure local authority and accountability; assess the pros and cons of different models of local governance. Define the elements of and staffing needs of these models.
- Identify a number of successful existing New Jersey local/county accountability structures. Define the elements of and staffing needs of these models.
- Develop a list of recommended models and resource needs for each recommended model.
- Make recommendations for how to fund the resources that will be required to support a more definitive authority on the local/county level (i.e., State offers X amount of dollars for support needs for this function and counties have parameters for how to spend).
- Make recommendations for the best way to engage New Jersey counties/areas in

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embracing one of the recommended models or variations of one to achieve the goal of local oversight and accountability.

Best practice in systems of care requires a strong local governance structure with clear authority. This authority must oversee both development of an array of services and supports that meets the unique needs of each locale and have responsibility for oversight. This type of local authority is not yet established throughout New Jersey and is essential for building stronger systems of care in each county/area of the State.

In addition to the development of a strong local governance structure, the following issues should be addressed:

### **Local Level**

- 1) Local boards, councils and committees would benefit from the development of individual Terms of Reference (TOR) that can be shared across entities. Terms of Reference are detailed in a document outlining the purposes of a board or council, how it will be structured and implemented. TOR establish common ground and a common understanding of why a group has been formed and what is expected. It is a proactive way to ensure that there is agreement about the vision, values, goals, objectives, scope, boundaries, resources, and authority. The development of TOR for each board, council, and committee at the local level would allow stakeholders to identify areas of duplication and clarify functions and responsibilities across entities. In addition, the TOR can include a clear statement of communication linkages and mechanisms with other groups.
- 2) At the local level there are several entities that are not consistently represented in the local children's behavioral health system across counties/vicinages, including Developmental Disabilities, Substance Abuse, and Education. Focus group participants stressed repeatedly that the lack of engagement and participation on the part of above entities has had a negative impact on the children's behavioral health system.
- 3) Local system partners, both within the county/vicinage and across the state, will benefit from the development of communities of practice to foster system wide problem-solving and knowledge sharing (see McDermott, 1999 and Rosenheck, 2001, for further description of communities of practice).

### **System/Policy**

- 1) Policy development and implementation require input from the local systems. In regard to system change, policies implemented through mandates and edicts are rarely successful in creating and sustaining lasting beneficial changes (Nutt, 2002, pp. 98–104). System/policy change requires buy-in from all system partners for successful implementation (Fixsen et al. 2005). Planned and recurrent forums for system partners to share information with DCBHS and give feedback on potential policy changes will be required for successful implementation of children's behavioral health system efforts. In addition, the DCBHS would benefit

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from collecting information and input from existing groups such as developing communities of practices and CIACCs, on a regular basis and utilizing that information to guide policy and system change.

- 2) Bring missing system partners to the table; inviting system partners that are not yet true partners to participate in a forum where information sharing is supported and mutual concerns are highlighted may lead to increased engagement, mutual ownership, participation, and buy-in. (Nutt, 2002, pp. 105-110)
- 3) Given the variation in counties/vicinages across the state of New Jersey, policies regarding the children's behavioral health system will need to have more focus on function and less on form. Through the continuous buy-in and information sharing process with system partners, consensus can be reached on what functions need to be accomplished to support the children's behavioral health system. Once the functions have been agreed upon by system partners, the local systems will be in a better position to determine the group(s), activity, reporting, etc. (the form) that will work best at their respective local level. With a focus on functions as opposed to form perhaps counties/vicinages will need fewer *waivers* and *work-arounds* to accomplish what has been asked of them from the state level and what is needed to realize benefits for children and families.
- 4) Communication from the state level needs to be standardized and recurring providing system partners with opportunities to critique and give feedback on the processes as they are implemented as well as proactive opportunities to help develop solutions (e.g., structures, policies, procedures). Input from system partners as to the type of information needed and the best formats/venues for receiving information will enhance their ability to be a true system collaborator and provide the best services to children and families.
- 5) In conjunction with input from local system partners and current Team Leaders, the role and functions of the Team Leader need to be clearly articulated as well as streamlined and reduced. Expectations for Team Leaders should be linked to, and supported by, clear rationales focused on system development and service improvement as opposed to using the Team Leader as a *catchall* problem solving position. In addition, consideration needs to be given to the size of the area per number of Team Leaders. Areas with multiple counties may require more than one Team Leader to successfully meet the needs of the community and to reduce the overwhelming burden on Team Leaders.

## Overall Recommendations Regarding Governance

The primary recommendation is that DCBHS should develop an inclusive and effective interagency body, whose responsibility it is to provide oversight and policy level decision making at the State level. After the establishment of this interagency structure, a review of all areas of governance is recommended. Initial areas to consider and questions to be asked include, but are not limited to:

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- Authority to govern: Establish the authority of the interagency structure through executive order, regulation, interagency agreement, or some other means.
  - Clarity about what is being governed: As spelled out in the Target Population section of this section of the report, go back to the basics and establish who will be served and the array of services and supports, indicating what services and supports are available from each State agency. Then, establish clear, non-overlapping, working structures on the regional and/or local/county/area levels. Define the relationship between the regional/local structures and the State level structure.
  - Is representative: Ensure that all stakeholders on the State, regional/county/area levels have representative voice in the governance structures.
  - Capacity to govern: What are the needs of the different governance structures? Does DCBHS have sufficient numbers of staff, and staff with expertise about child mental health and systems of care, to manage the system? Do the regional or county/area structures have sufficient staff to accomplish the tasks needed? Have the tasks of each been defined?
  - Credibility to govern: Strong and sustained leadership with excellent communication skills and strategies is needed. Transparency on all levels is desired.
  - Assume shared liability across systems for the target population: New Jersey needs to review this area. What can each State agency bring to the table in order to be a full partner?

As spelled out by a study of the impact of policy on collaboration in system of care, Evans and colleagues (2004),

**“A tiered infrastructure of interagency coordinating entities at the state, regional, and local levels supports collaboration in system of care development. The local level coordinating entity provides mechanisms for interagency child and family service planning teams. The county/regional level entity provides functions such as needs assessment, identification of service gaps, and allocation of new resources. The state level coordinating entity addresses cross-system policy development, state-level barriers to collaboration, and mechanisms to allocate new funding.”** (p. 2)

It is recommended that New Jersey establish such infrastructures and fully develop them into successful mechanisms that promote inclusiveness and effective problem solving. A recent report on sustaining systems of care (Stroul, 2006) identifies three strategies, — cultivating strong interagency relationships, involving stakeholders, and using evaluation results — that, according to stakeholders, are not strengths of the current New Jersey system.

Concerns about children and families in child welfare receiving timely and appropriate behavioral health services, as shared above, was also a major concern raised by a number of stakeholders. Several stakeholders did believe that “once the high turnover of child welfare case managers reduces and supervisory staff are trained” most of the concerns expressed

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to date about accessing behavioral health services would be addressed. As part of the child welfare settlement, DCF and DCBHS are reviewing the best approaches to provide mental health services and supports to children involved in the child welfare system.

One state that has addressed this issue is Arizona. In 2000, Arizona had considered developing a separate mental health system for children in the child welfare system. The State ended up identifying the changes needed in children's behavioral health to better serve children in child welfare, and are now noted nationally for their successes. Some of the changes include developing specialty services for children with unique needs (e.g., trauma, sexual abuse) and addressing and resolving competing case management systems and even, competing treatment and care plans. A child and family team is created for each child, most often with staff from the child behavioral health system leading the team, but sometimes the child welfare case worker leads the team and sometimes even the family member or a friend of the family. The goal is to have 100% of child welfare children in custody served by child and family teams within the next year (Frank Rider, Bureau Chief, Arizona Department of Health Services, Bureau for Children's Services, Division of Behavioral Health Services, personal communication, August 24, 2006).

The most important task for the leadership staff of the newly created Department of Children and Families, and the Division of Child Behavioral Health Services, is to provide strong leadership based on best policy and practices in the children's mental health field.

## **Vision and Practices**

First and foremost, it is important for the leadership to understand children's mental health and to define New Jersey's plan to address the mental health needs of children throughout New Jersey and their families. Utilizing a blueprint based on best practices, DCBHS should:

- Develop a new, written vision for children's mental health that builds on the work accomplished to date and addresses areas not yet developed within existing New Jersey system of care (e.g., specific evidence-based practices, full partnerships with all child/adolescent & family serving agencies). Ensure wide representation in the development of this vision and ample opportunities for feedback from throughout New Jersey.
- Leaders must highlight successes and not just focus on problems. Ensure that existing best practices within the New Jersey system of care for children and families are identified, and that the intention to maintain specific practices is clearly and widely communicated to all constituents and interested citizens. For instance, New Jersey has been identified as a lead state in beginning to operationalize some system of care values in every area of the state (e.g., family partnerships, use of wraparound). This should be highlighted. Meaningful roles for families and family organizations, as well as youth, at all levels of government, and as providers of support services, should be maintained and strengthened.



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- Translate the new vision into practice — outlining the full array of services and supports within the existing system of care — and the service array that the Department will move to implement, with specific goals and timeframes (understanding that some goals will be achieved after task forces have researched areas and developed plans to address). This document of goals and timeframes could be built upon, and including recommendations from throughout this report, become a strategic plan for DCBHS.
  - Develop a plan to bring all mental health services and supports into the system of care. Review all licensed existing services (e.g., residential, outpatient, day treatment) and develop a plan to ensure their services are improved, consistent with system of care values, and brought into the best practice arena. Create regulations and licensure for currently unlicensed services.
  - See also the recommendations in the section on Target Population in Chapter 5: Service Array.

## **Full Partnerships with other Child/Family Serving Agencies**

- Translate the vision of full partnerships into practice – with a plan to achieve full partnerships with all child and family serving systems
- Develop a state level oversight and accountability structure: with leaders from all New Jersey child and family serving systems, as well as family, youth and advocate representatives, develop a structure to support real partnerships (e.g., a workgroup or council, that includes all commissioner level/departments heads with specific tasks for assessing system needs and problem solving solutions to barriers identified by regional/local groups
- Identify existing New Jersey counties where cross system structures are successfully operating. From this review, define a local system oversight, problem solving and accountability structure
- Identify the unique service and support needs of children and families involved in different systems (e.g., child welfare, juvenile justice, developmental disabilities, and Education). Appropriate representatives from these systems should be identified to staff specific task forces/workgroups addressing the specific needs of these children. After an assessment of what is already in place and working, develop plans to improve existing behavioral health services and supports, and introduce new service and support offerings for each identified group of children and families.

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## **Communication, Transparency and Accountability**

Government must be transparent in its dealings to ensure accountability. The new Director of DCBHS has already expressed the intention to ensure transparency and accountability of all functions within DCBHS. Plans should be developed to ensure that communication and transparency are priorities for both DCF and DCBHS. Formal and informal feedback mechanisms should be developed to assess effectiveness of this leadership team in achieving effective communication, being transparent in all interactions and focusing on accountability. Leadership must employ marketing strategies and fully develop continuous quality improvement systems to ensure a continuous focus on feedback and improvements, develop, implement and maintain structures (i.e., training, coaching, evaluation) to support best practices in services/supports and system of care local structures.

Leadership staff must become experts at change management strategies that support further development of evidence-based practices within systems of care in every county in New Jersey. Suggestions in this area are included under the chapter on Evidence-Based Practices of the report.

In summary, New Jersey's children's behavioral health system has many strengths. New Jersey has a long history of making improvements in care for children with special needs and their families. DCF and DCBHS leadership are at a critical juncture, and need to carefully build a stronger foundation for serving children and youth with mental health needs and their families. This foundation should build on and capitalize on many of the existing strengths of the system, including staying committed to fully system of care values, such as family-driven, youth-guided, culturally competent and community-based care for all children with behavioral health needs and their families throughout every county of New Jersey. ■



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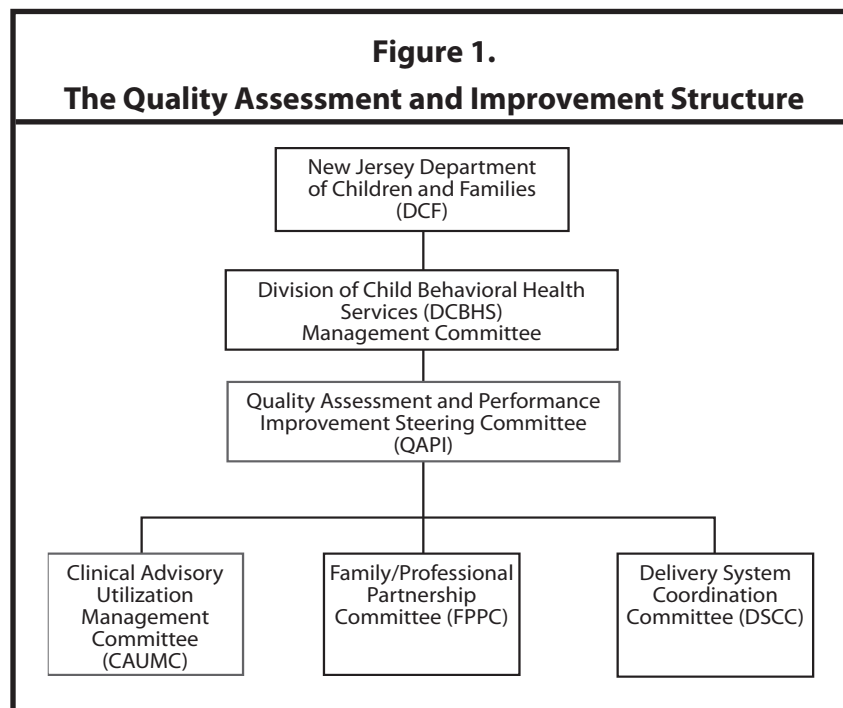
## Chapter 2: New Jersey's Continuous Quality Improvement Program

### Background

One of the self-identified key areas of reform in *The Children's Initiative Concept Paper* (State of New Jersey, 2000) was the development of a Continuous Quality Improvement system in which the goal is to systematically monitor, analyze, and improve service delivery performance to enhance program outcomes for children and families. The State's underlying values and principles are succinctly stated in the following excerpt from The Plan (NJ DHS, 2004) and are inherent in DCBHS Quality Vision and 2006 Goals described in the QAPI Program Description (New Jersey Division of Child Behavioral Health Services [DCBHS], p. 163, 2005).

**"To ensure that New Jersey's child welfare system is continuously improving to meet the needs of children and families and the commitments in this plan, we will develop a robust program of continuous quality improvement (CQI) that will regularly evaluate all aspects of the system, both quantitatively and qualitatively, and this program will be institutionally positioned and operated in such a way that its findings lead directly to necessary programmatic improvements."**

**Figure 1** below depicts how these steps would be operationalized within the redesigned system of care.



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Although The Plan identified specific implementation targets and milestones for the CQI system, a redesign initiative as comprehensive and complex as this presumes the need for flexibility and course adjustment throughout the implementation process. As such, this assessment will primarily focus on the functionality and effectiveness of the CQI infrastructure in the context of the intended objectives and outcomes as it exists at this point in time.

## Method

The infrastructure and mechanisms for managing information and ensuring accountability and quality improvement were examined. Specific areas of investigation included:

- A review of the information/data that is collected within the Children’s Behavioral Health system
- Examination of the feedback loops throughout the system, including interagency information dissemination and integration, to determine adequacy in design and implementation;
- Review of clinical (qualitative) and functional (quantitative) outcome measurements;
- Review of consumer (youth and family/caregiver) satisfaction measures (process and outcome measures);
- Review of the performance of the ABSolute Information System in the context of the overall continuous quality assurance and improvement system.

## Section II: Assessed Strengths, Identified Needs and Recommended Improvement Opportunities

Quality assurance programs designed to assess performance, inform decision-makers, and result in performance improvement are ubiquitous in contemporary children’s services initiatives throughout the nation, but in practice take on many structures. While no single state model exists against which DCBHS’s CQI program can be compared, the National Child Welfare Resource Center for Organizational Improvement (NCWRCOI) developed a framework that includes the broad elements that all quality assurance systems should consider in creating new CQI systems. *A Framework for Quality Assurance in Child Welfare* (NCWRCOI, 2002) includes state examples that assist in conceptualizing practical application within individual agencies. This model is an excellent resource for state and/or local agencies developing or assessing the integrity of a comprehensive quality assurance and improvement system.

The Framework provides a practical five-step outline useful to the development and implementation of CQI systems. These steps are:

- Adopt outcomes and standards
- Incorporate QA throughout the agency
- Gather data and information
- Analyze data and information
- Use analyses and information to make improvements

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This assessment of DCBHS Continuous Quality Improvement system that follows, including strengths, identified needs and recommended improvement opportunities are organized in Section II using an adaptation of this framework.

## **Adopting Outcomes and Standards**

Both performance outcome measures and process measures are identified in the DCBHS system. A review of the QAPI Program Description reveals the following priority clinical and non-clinical indicators that are recommended by the Steering Committee for 2006–2007:

- Number of referrals by source, location (county or CMO area), age, ethnicity and sex.
- Number of referrals screened (EPSDT), assessed, multi-system assessed by Diagnosis, location, age, ethnicity, and sex.
- Number of referrals assigned to the CMO statewide and by diagnosis, location, age, ethnicity, sex and referral source.
- Number of referrals accepted and assigned to CSA care coordination statewide and by diagnosis, location, age, ethnicity, sex and referral source.
- Number of children referred to the system of care not accepted by location, age, ethnicity, sex, and referral sources and reason.
- Number of referrals and accepted children eligible for Medicaid, NJ Kidcare/Family care
- Number/Percent of children accepted in the Children's Initiative with service plan completed within required timeframe by diagnosis, location, age, ethnicity and sex.
- Number/Percent of children in the Children's Initiative with service plans in place and services authorized within required time by diagnosis, location, age, ethnicity, sex
- Number of children in the Children's Initiative who are authorized to receive service but are not receiving service or receiving partial services by Diagnosis location, age, ethnicity, sex
- Amount of dollars spent for children in the Children's Initiative by child, diagnosis, eligibility type (CMO, CSA care coordination) location, age, ethnicity, sex, service type
- Number and type of complaints by provider (at present cannot separate by provider), DYFS, law enforcement, Courts by location, sex and source
- Amount and type of service used (hours, days) per child by diagnosis, eligibility group, location, age, ethnicity, sex
- Number of providers by service type by location, county, CMO area
- Amount of time from receipt of referral to screening, from screening to decision on enrollment, from enrollment to service plan completion, from service plan completion to service authorization, from service authorization to service delivery by location, county and CMO
- Drug utilization
- Telephone responsiveness — percent of calls to the contractor that are abandoned
- Telephone responsiveness — percent of calls answered in 5 rings (or 30 seconds) or less by a person

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- Timeliness of service authorization — percent of service authorization decisions for continued stay in inpatient services made within 24 hours after receiving assessment information from a clinical provider or screening team
  - Timeliness of service authorization — percent of admission and continuation of care decisions for routine care for non-CMO children made within 5 working days after receiving a service request with all of the clinical information required by, and stated in, written CSA policy
  - Timeliness of service authorization — percent of interim plan and ISP reviews for CMO children made within 24 hours after receiving a proposed plan with all of the clinical information required by, and stated in, written CSA policy, stratified by: interim plan, ISP
  - Child and family involvement — percent of the following types of CSA committees and activities upon which youth and families serve as members: quality assurance, grievance and appeal, child and family/caregiver service and/or education, service planning, utilization management, policy, program development, human resources development, committee membership lists
  - FSO involvement — percent of CMO families referred to FSOs, percent of families in crisis referred to FSOs
  - Restrictiveness of living environment — percent and number of children who moved to a less restrictive living environment from entry to exit
  - Readmission rate — percent of children discharged from an inpatient facility readmitted within 7, 30, 90, and 180 days after discharge, stratified by age
  - Functioning — percent of change in [Strength and Needs Assessment scores] (entry score, score at review period, exit score)
  - Placement stability — number of children unable to be maintained in current placement for emotional or behavioral reasons from ISP
  - RTC length of stay — percent of change in RTC lengths of stay: Per child–Per 100 children
  - Adequacy of crisis management — number of crisis screenings reported to the CSA: Per child· Per 100 children
  - Timeliness of crisis management follow-up — percent of children discharged from crisis management that receive a service within three days
  - Timely outpatient or community-based services follow-up to inpatient treatment — percent of children discharged from inpatient care who receive outpatient or community-based services within seven days
  - Timeliness of services — Length of time from request for service and face-to-face visit
  - Coordination with the primary care Medicaid HMO physician (PCP) — percent of children receiving psychotropic medications whose provider is actively coordinating with the Medicaid HMO PCP, excluding children without an assigned PCP.

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Some performance outcomes measures (“Performance Targets”) are identified in CMO, YCM, and MRSS service contracts. Although each CMO, YCM, FSO and MRSS contract is the same for each provider delivering that particular service, it is notable that there are no child and family outcome measures common to all in the existing contracts. Process and practice criteria are described for each performance target. None of the QAPI indicators discussed above that apply to CMO, YCM, FSO, or MRSS services are included in the current contracts.

As reported in focus groups and the web survey, providers state that each of their agencies have established quality assurance and improvement programs, goals and performance standards beyond those identified in their contracts. Many report that they use their own data to supplement data received through DCBHS and CSA including client satisfaction data to assess their agencies’ performance. There is an absence of consistency among provider agencies in this regard.

The Contracted System Administrator contract with CSA contains numerous contract deliverables which describe quantitative performance expectations for a broad array of processes and procedures. Certain outcomes for service quality directly related to children and families are included in measures relating to timeliness of assessment, service authorization, and referral. These items are included in the recommended performance indicators listed above. Responsiveness to consumer grievances and complaints are also among the performance expectations, although the contract does not require this be analyzed or reported.

Currently, CQI planning at DCBHS is focused on refining and expanding outcome expectations for children and families and expanding performance-based contract requirements for the service delivery system. The recommendations included in the QAPI 2006–2007 Program Description have been submitted to DCBHS to inform the planning process.

DCBHS is developing a plan for a 3-step enhancement to the quality assurance and improvement process that includes:

- 1) **Data “dashboards” and provider profiles:** A data driven focus on four performance axis: Access, Utilization, Compliance and Outcomes. CMO, YCM, FSO and MRSS providers will be the initial focus, and then the system will be applied to out-of-home care providers.

This step will include the establishment of regular performance measures that will be included in routine reports on the functioning of each system partner. Set targets will be established for each measure. DCBHS will work with system partners to reach consensus on the measures and ensure understanding in the use of the dashboards. Information available to all system partners will be consistent, uniform and routinely available. These are features that have not been inherent in the current system and respond to both the state’s needs and the expressed needs of system partners.

- 2) **Local System of Care Evaluations:** Aggregate data on local (county) service system capacity and performance as a whole (i.e., not provider-specific).

Once baseline data has been established, this step will allow for analysis of aggregate

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performance data on a local system level (county or vicinage). These system-wide evaluations of the local systems of care are expected to better identify local needs and assist in identifying successful outcomes or where improvement is needed. This type of assessment will provide DCBHS and local partners the opportunity to use data to understand where its system needs are unique and how it can better target services based on customer needs.

- 3) **Outcome Measures:** Methodologically rigorous outcome measurements will be used to evaluate performance of providers to reach positive results for children and families. Performance on three key outcomes will be the initial focus: keeping children (1) at home; (2) in school; and (3) out of trouble. These outcomes are central to the operation of the system of care.

It is anticipated that this process will deepen the understanding of how services translate into improvement of life outcomes for children and families served. One goal of these evaluations will be to better understand and share best practices in the system resulting in improved outcomes for all providers.

The proposed plan uses both quantitative and qualitative information to measure and evaluate the performance of the service system in a balanced manner, and takes account of variability in strengths and resources at the local level.

## Identified Strengths

1. The QAPI Program Description plan clearly articulates key outcome standards and indicators which reflect the underlying values and principles for the system of care.
2. DCBHS has made limited progress in developing performance-based contracting. Performance targets with milestones, projections, and verification procedures are included in the CMO and MRSS contracts. DCBHS is working with system partners in planning the next steps in refining and expanding this process.
3. There is a system-wide recognition that customer satisfaction and input is important to quality assurance and improvement efforts.

## Identified Needs and Recommendations

1. Primary outcomes standards for children and families should be standardized throughout the service delivery system and well articulated in service contracts. Equally important will be ensuring that all outcome standards are measurable and the method for calculating performance is clearly established.
2. Broad stakeholder input, including consumers, providers, and advocates would be helpful when modifying or expanding system level outcome standards.
3. A review of practice/performance standards will be important to ensure that they continue to support and complement established outcome standards. Practice and performance standards that drive desired outcomes for children and families should be emphasized.

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4. Selection of process standards to be included in performance-based contracts should emphasize quality over quantity.
  5. DCBHS should consider a mechanism to coordinate and integrate consumer satisfaction data collected by local service providers into the statewide consumer satisfaction survey process. This would reduce duplication of effort, provide standardized local and statewide results, and increase response rates.

## **Incorporating Quality Assurance and Improvement Throughout the System**

A review of DCBHS's system of care reveals that quality assurance and improvement activities are in place in many agencies and levels within the system but are not well aligned and/or integrated with each other.

All CMO providers (100% of respondents to the web-based survey) and 80% of YCM providers report using overall program data for planning and developing quality improvement programs within their individual agencies. There are recent emerging activities that suggest providers are beginning to share such information among themselves although many express the desire for a centralized collection, reporting and dissemination mechanism. Such a mechanism would allow for formalized periodic comparison of performance across providers as well as set the stage for additional sharing of best practices in service delivery and performance improvement planning.

**Table 8** below depicts the combined responses from CMO and YCM Directors, and DCBHS Quality Assurance staff to questions regarding use of data for system planning. The survey results are remarkable due to the relatively high percentage of respondents who answered "Do Not Know" for each question.



<b>Table 8.</b> <b>Aggregate Results of Survey Question Regarding</b> <b>Information Used for System Planning</b>			
	Info used for system planning?		
	(N=22)		
	Yes	No	Don't Know
Demographics of children/families served	59% (13)	9% (2)	32% (7)
Demographics of children/families eligible to be served	48% (10)	19% (4)	33% (7)
Service Gaps	62% (13)	10% (2)	29% (6)
Caseload amounts or ratios	73% (16)	14% (3)	14% (3)
Position Vacancies (contracted services)	55% (11)	20% (4)	25% (5)
Child Satisfaction	36% (8)	23% (5)	41% (9)
Family Satisfaction	55% (12)	14% (3)	32% (7)
Timely access to services	45% (10)	32% (7)	23% (5)
Child Behavioral Health Penetration Rates	10% (2)	14% (3)	76% (16)
Service Utilization	50% (11)	9% (2)	41% (9)
Service Utilization by Culturally Diverse Groups	19% (4)	29% (6)	52% (11)
Service Utilization–Child in CW System	30% (6)	30% (6)	40% (8)
Service Utilization Child in JJ System	30% (6)	35% (7)	35% (7)
Total cost of services	45% (10)	9% (2)	45% (10)
Cost per child serviced	35% (7)	20% (4)	45% (9)
Cost shifting among child-serving systems	5% (1)	35% (7)	60% (12)
Improvement in child outcomes	38% (8)	24% (5)	38% (8)
Percentage of Services received that are in treatment plan	30% (6)	30% (6)	40% (8)
Quality of treatment/service plans	43% (9)	29% (6)	29% (6)
Percentage of Youth Served in County/Counties	38% (8)	29% (6)	33% (7)
Percentage of Youth Served in State	45% (9)	25% (5)	23% (6)
Out-of-home placements	73% (16)	5% (1)	30% (5)
Consumer complaints	57% (12)	10% (2)	33% (7)

Although a variety of data exists and is made available statewide through the CSA (see **Gathering Data and Information**, p. 49 below), the majority of this information is focused on customer demographics and number of children served in various program types, not child and family outcomes. There are examples of system performance reports that are especially useful to decision-makers and stakeholders such as the Inpatient Re-admission Trend Analysis Reports and Inpatient Follow-up Trend Analysis Report. The scope of distribution of these reports is unclear.

The CSA has recently conducted focus groups for providers and related stakeholders to identify data and report needs and related customer service concerns such as navigation,



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training, and other user-specific issues. CSA indicates that information gathered through these focus group efforts will be used to develop recommendations to DCBHS. Decision-making authority regarding production and distribution of any such reports and data sets is with DCBHS. Routine changes, such as response to system glitches, are attended to directly by CSA and outcomes are reported in the Weekly Status Reports distributed by CSA.

Providers of direct service who participated in focus groups conducted by the Independent Assessment Team consistently expressed frustration about the limited amount of useful data that has been available to them. For example when participants of the focus group for YCM Directors were asked to identify key priorities the review team needed to understand, the first response was stated emphatically: “We need data.”

The ability of DCBHS to fully incorporate quality assurance throughout the system may be limited in part by several factors identified during this assessment:

- Care Management Organizations are contractually required to develop and maintain quality improvement programs within their agencies. However YCM, FSO, MRSS providers do not have this requirement. Although some do maintain quality improvement programs, there is no consistency among any of these providers.
- The CSA, ValueOptions New Jersey, has a formal quality assurance department. However with the exception of coordinating the QAPI Steering Committee, QA/QI activities are focused on internal non-clinical process issues, not the broader system of care’s performance.
- Routine data reports and those generated through special request (ad hoc) from DCBHS are more closely related to who the system is serving rather than how they are being served and what outcomes are achieved. This information may be useful at the state office level but is of limited value to the service delivery system regardless of the scope of distribution.
- The QAPI Committee structure is not provided with routine quality-focused data or information to effectively plan or assess the status of the system’s performance. Because participation in this committee structure is voluntary and any outcomes are available only through meeting minutes, there is very limited dissemination of the committee’s work throughout the system.

## Identified Strengths

1. Most direct service providers have developed resources and capacity for internal quality assurance and improvement functions within their respective agencies.
2. There are many established forums throughout the system where providers, state officials, and community leaders have opportunity to share information about activities, accomplishments, strategies, and improvement opportunities. These committees, advisory groups, etc. meet regularly and have maintained a high level of participation by stakeholders.
3. The CSA’s ABSolute information system has the capacity to gather and disseminate the information necessary to support informed decision-making at all levels of the QAPI structure.

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## Identified Needs and Recommendations

1. Uniform outcome and performance standards should be established for direct service providers and incorporated into service contracts. Process, practice, and child and family outcomes should be included in these measures.
2. DCBHS should consider incorporating and standardizing the quality assurance and improvement resources currently in place at the service provider level into its overall continuous quality improvement strategy. Care should be taken to avoid duplication of effort which may expand the efficiency and effectiveness of existing resources.
3. Standards for continuous quality improvement programs at the direct service level should be included in service contracts and monitored. The QAPI Steering Committee could be a highly effective means to develop these strategies given the broad scope of expertise available from its membership.
4. The role of the CSA in the overall Continuous Quality Improvement Program should be reviewed. The current relationship between the CSA and QAPI Steering Committee is both administrative coordination and functionally, co-leadership although it is unclear why the Committee is not aligned more closely with DCBHS. There is an inherent conflict of interest between QAPI's review and oversight role relevant to the CSA and the operational structure. DCBHS should co-lead the QAPI Steering Committee with a provider under a revised Mission and Philosophy that is enhanced to include true public/provider collaboration.
5. Quality standards and expectations for the CSA's internal CQI program should be more clearly articulated in their contract to include clinical services, especially assurance regarding the validity of the screening and assessment services (e.g., mechanisms for establishing inter-rater reliability).
6. The existing contract with the current CSA will soon expire. Re-bidding of the contract provides an opportune time for DCBHS to assess their needs related "to support utilization management, care coordination, quality management, and information management for the statewide system of care..." (State of New Jersey, 2000) Examples of what to review include, but are not limited to:
  - What are the benefits of a statewide CSA versus regional CSA's (as used in Arizona) or county/area (as used in Pennsylvania)? If a statewide CSA is to be chosen, then what can be done to adapt to and be responsive to county/area needs?
  - What are the CSA deliverables most important to DCBHS at this time? What functions does DCBHS need from a CSA in order to deliver services most effectively for the target population of children and their families?
  - Would any of the deliverables be more effectively implemented through another means (e.g., regional or county/area access and/or care coordination versus statewide)?

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- Do all, or even the majority of services, need to be approved by the CSA? It appears from the interviews with stakeholders that much of the *complaining and concerns* about the CSA in New Jersey relates to ease of access and concerns about the *legitimacy* and *validity* of the approval process.
  - How can a meaningful working relationship between the CSA and area/county interagency bodies be developed, so that possible specific area/county issues can be adequately addressed?
  - Would a focus on accountability be more likely if the CSA and providers were risk-based? What are the benefits of a risk-based system?

## Gathering Data and Information

Information pertaining to data and information gathering was obtained through desk review, interviews, and the web-based survey.

DBHS collects quantitative and qualitative data through multiple mechanisms established at the service provider, CSA, and state agency level. The CSA has responsibility for collection and maintenance of data using its ABSolute system.

The CSA's Information Technology Director indicated that ABSolute compiles over 600 reports using this data and most are available through its Report Web Portal for authorized users. Reports available include all child demographics by county, service type, etc., There are separate reports for each county by each service (CMO, YCM, MRSS, etc), and summary reports for each. The same method is used for segregating reports for such indicators as demographic errors, child demographics in detail, and other process related reports such as children without service plans, progress report summaries, service expiration, and service plan tracking.

While 600 reports seems excessive, it is important to note that segregation of like information into individual reports contributes significantly to this volume. For example, in the case of children's Summary Demographics Report, the same 13 demographic elements are reported in separate reports for each service type and by county. Another set of reports, Children Detail, provide all child demographic information segregated into separate reports for each service and county. There are also combined reports for all counties by service type. Most of these reports have a corresponding Demographic Error report as well.

The ABSolute system is also used to collect and report CSA service level and performance information such as calls received and abandoned, authorization approvals, etc. CSA maintains an internal Quality Assurance department that is accountable for tracking and reviewing the performance of clinical and other client service staff who are responsible for processing requests for services. The CSA's Quality Assurance Department does not have responsibility for qualitative review of clinical services, such as administering needs assessments. This function is performed within the Clinical Services department at CSA under the supervision of the Clinical Director. According to the clinical director, case reviews and a required annual corporate inter-rated reliability study are the primary clinical quality assurance activities.

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As with any automated information system, the value of the information developed is fully dependent on the integrity and completeness of data input into ABSolute. There is evidence that the service delivery system is continuing to develop capacity and competency as it adjusts to automated case documentation, however the current status appears to be below a performance level that supports confidence in reported information.

For example, recent CMO Error Reporting Summaries (6/13/2006) provided through ABSolute finds an aggregate CMO Accuracy Average of 83.3%. The range for all CMO's in that reporting period was 73.9% to 91.8%. The YCM aggregate Accuracy Average for the same period is 55.9% with a range from 49.8% to 89.3%. These reports identify missing information for 14 demographic fields for each case. In addition, case sampling activities associated with other components of this Independent Assessment relied on ABSolute data for the identification of active cases in 3 service areas. Follow-up activities by members of the Independent Assessment Team using this information found that a significant percentage of the children identified did not have active cases (e.g., One county 23%; n=13: and in many cases, it could not be determined that the children had active cases in the past).

Equally important to the value of data is knowledge of the availability of data for decision-making leadership, planners, and service providers throughout the system. The web-based survey conducted for this assessment as well as stakeholder interviews revealed broad inconsistencies in the knowledge-base and perceptions regarding data collection and availability. Table 9 below depicts the aggregate response of DCBHS CQI staff and CMO/YCM directors who responded to the survey questions regarding type of information tracked.

<b>Table 9.</b>			
<b>Aggregate Results of Survey Question Regarding Information Tracking</b>			
	<b>Info tracked?</b>		
	(N=22)		
	Yes	No	Don't Know
Demographics of children/families served	100% (22)	0% (0)	0% (0)
Demographics of children/families eligible to be served	55% (12)	23% (5)	23% (5)
Service Gaps	86% (19)	5% (1)	9% (2)
Case load amounts or ratios	95% (21)	5% (1)	0% (0)
Position Vacancies (contracted services)	64% (14)	14% (3)	23% (5)
Child Satisfaction	50% (11)	18% (4)	32% (7)
Family Satisfaction	82% (18)	5% (1)	14% (3)
Timely access to services	68% (15)	23% (5)	9% (2)
Child Behavioral Health Penetration Rates	14% (3)	14% (3)	73% (16)
Service Utilization	77% (17)	0% (0)	23% (5)
Service Utilization by Culturally Diverse Groups	45% (10)	9% (2)	45% (10)
Service Utilization–Child in CW System	55% (12)	9% (2)	36% (8)
Service Utilization Child in JJ System	50% (11)	14% (3)	36% (8)
Total cost of services	68% (15)	14% (3)	18% (4)
Cost per child serviced	45% (10)	18% (4)	36% (8)
Cost shifting among child-serving systems	9% (2)	36% (8)	55% (12)
Improvement in child outcomes	55% (12)	14% (3)	32% (7)
Percentage of Services received that are in treatment plan	36% (8)	27% (6)	36% (8)
Quality of treatment/service plans	50% (11)	27% (6)	23% (5)
Percentage of Youth Served in County/Counties	45% (10)	18% (4)	36% (8)
Percentage of Youth Served in State	50% (11)	23% (5)	27% (6)
Out-of-home placements	100% (22)	0% (0)	0% (0)
Consumer complaints	73% (16)	5% (1)	23% (5)

As shown on **Table 9**, demographics of children and families served and out-of-home placements were the only items all respondents understood to be tracked. As the Table reveals, there is considerable disparity in knowledge of the scope of data gathered within the system among this group of respondents. A similar degree of disparity was found in the results for each of the above groups when analyzed separately. Highly restrictive distribution or access to this data during the implementation phase of this initiative may be a leading factor in this limited understanding, as may be the fact that data-driven quality improvement and service planning has played a small role thus far.

Qualitative data is primarily acquired through Quality Service Reviews (QSR) conducted in counties. Since October 2005, the QSR's were expanded beyond issues relating directly

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to child protection services to include those specific to children's behavioral health services. Four counties have completed their QSR's using the enhanced protocol. These four reviews were considered "pilot" sites and the outcome is currently under review for statewide implementation.

As described in the protocol, the QSR uses an in-depth case review method and practice appraisal process to find out how children and their families are benefiting from services received and how well locally coordinated services are working for children and families. Each child/family served is a unique "test" of the service system. Samples of children are reviewed to determine child and parent/caregiver status, recent progress, and related system practice and performance results.

Detailed stories of practice and results and recurrent themes and patterns observed across children and families are reviewed leading to a deeper understanding of contextual factors that are affecting daily frontline practice in the agencies being reviewed. Quantitative patterns of child and family status and practice performance results, based on key measures are examined.

A QSR review culminates on the final day when all findings are reviewed and action steps are developed to address issues identified. Local stakeholders work as a group to identify these areas and a leader is assigned responsibility for follow-up on action steps that are developed. Noteworthy accomplishments and success stories, emerging problems, issues, and challenges in current practice situations are explained in local context. Monitoring reports are produced that reveal the degree to which important requirements are being met in daily frontline practice.

Many focus group participants and individuals interviewed as part of this assessment reported high satisfaction with the QSR process and learning a great deal about strengths and needs within their service delivery system. The process has not yet evolved to the point where findings from these county-wide reviews have been used to determine statewide service quality or performance improvement plans.

## **Identified Strengths**

1. CSA's ABSolute system has a demonstrated capacity and flexibility to gather and disseminate data at every level of the service system although its potential has not been realized in this application.
2. The QSR process was reported by interviewees to result in new local understanding of the system's needs and strengths.

## **Identified Needs and Recommendations**

1. Data errors and missing data rates indicate that staff training and oversight activities at the provider level should be expanded in order to ensure accuracy and usefulness of information for planners and decision-makers.
2. All service providers whose staff have data entry responsibilities should have clearly defined performance expectations included in their contracts, including specific



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quality assurance and improvement strategies in this area. Staff should have these duties and responsibilities included in their job descriptions. Accountability for complete and accurate data entry resides with the providers including the CSA.

3. Meaningful reporting on data error rates should be included in routine information distributed to DCBHS and the service system such as in the Weekly Update Reports.
4. DCBHS should review the current data reporting formats and consider opportunities to consolidate demographic reports. The current array of reports provides volume but not commensurate value and they are not conducive to comparative analysis.
5. The ABSolute Report Portal site should continue to be reviewed through the focus group process initiated by CSA and significant effort should continue toward improving end-user friendliness and useful reporting contents and form.
6. Staff training on the ABSolute system and performance requirements should remain a continuing priority at all levels. Staff training methods and frequency should take into consideration the schedules and workload of caseworkers and other field staff who are the primary training recipients to ensure maximum participation.

## **Analyzing Data and Using Information to Make Improvements**

The Child Behavioral Health Services Continuous Quality Improvement design plan includes the key elements that incorporate quality assurance throughout DCBHS's system of care. These include: creation of a quality assurance structure that is inclusive and ensures clear communication of performance goals throughout the system. Transparent and efficient flow of data and information throughout the system is also well articulated in this design. Figure 1 (page 47) above depicts the Quality Committee Structure. Central to this structure is the Quality Assessment and Performance Improvement Steering Committee (QAPI) whose primary mission is to identify, evaluate and implement clinical and service improvements relevant to the population served.

The QAPI Steering Committee was formed in 2003 as an inclusive statewide body and its membership includes provider agency staff, consumers, advocates, state agency representatives, and other interested stakeholders. The membership composition was designed to provide broad input into the system as well as facilitate a quality assurance "culture" throughout the system of care. The Steering Committee meets monthly. As shown in Figure 1, three standing sub-committees meet on specific issues and report to the QAPI Committee.

The QAPI Steering Committee is responsible for developing and recommending the Quality Assessment and Performance Improvement Program Description (DCBHS, 2005) for children's behavioral health services. Most recently revised in November 2005, this document described the mission, purpose vision and goals for continuous quality improvement and an overview of the scope of responsibility of the QAPI Committee, its sub-committees and

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priority projects for the current and future year. The program description is supplemented by a QAPI Workplan, an action plan describing activities planned to meet the plan's goals and objectives.

The QAPI Program Description is a comprehensive document that establishes and describes in detail all key areas of the service delivery standards, priorities and improvement planning activities, and it fully describes the role, scope, and functions of the Steering Committee and associated entities for review, oversight, analysis, and improvement planning for the system of care. The Program Description and scope of activity for this group is extensive and would be best described as an ideal. The ability to address and act upon all areas identified is questionable in the context of realistic capacity.

As depicted in **Figure 1**, the DCBHS Management Committee is a senior management level team at DCBHS that receives input and recommendations from the QAPI and utilized that information to inform policy development, practice, performance improvement strategies. Management team members participate in Committee meetings, as non-voting members, and information is formally transmitted to the team through meeting minutes which are electronically distributed.

A desk review of QAPI Steering Committee minutes reveals a broad range of subjects that serve to educate members on the broader system of care and the issues currently prioritized by sub-committees, DCBHS leadership, the CSA, service providers and community stakeholders. There are many examples of requests or recommendations for information or actions; however not all are focused on quality assurance and improvement actions specifically. While the committee discusses many system-of-care issues regularly, there is little evidence that indicates it serves a proactive advisory or steering function with regard to continuous quality improvement. It is striking that the Committee was provided an overview of the QSR plan and process in May 2006, seven months after the revised QSR protocol that included children's behavioral health focus items began pilot implementation. DCBHS Management Committee members provided the results of one county's QSR to the QAPI members in June 2006.

In 2004 and 2005 a statewide Customer Satisfaction review was conducted by CSA and the planning, review and subsequent recommendations based on findings was a major focus of the QAPI Steering Committee's role and function. The survey suffered from a poor response rate each year and statistically valid results were not obtained, however information received about the persons who did respond were reviewed by the QAPI Steering Committee and recommendations were made. Several points about this year's review are important to understanding strengths and needs of the QAPI process. First, the results of the survey were presented at a QAPI meeting and suggestions and recommendations were found documented only in the committee meeting minutes, not a formal report. It was reported through stakeholder interviews that DCBHS staff in attendance were responsible for reporting comments and recommendations to DCBHS.

Second, the minutes included several insightful comments and suggestions from committee members about strengthening the process such as collecting and reporting



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information received from the survey at a county level and comparing results to other states. Both suggestions were met with responses that identified the perceived difficulty in accomplishing these activities but no discussion of how any barriers might be overcome for future surveys.

Third, in **Table 9** above only 79% of respondents responded affirmatively when asked if family satisfaction information was collected and only 42% responded affirmatively when asked if child satisfaction information was collected. These results suggest that although much effort and resources are devoted to the statewide consumer satisfaction survey, it receives minimal attention, distribution and support for any recommendations that are generated.

It was also learned through stakeholder interviews that DCBHS's current review of the QAPI structure and process includes discussion with the Steering Committee leadership about new ideas for structure and function that may be conducive to fuller proactive input and guidance from the Steering Committee. This includes DCBHS assuming a leadership role. These recent efforts by DCBHS to enhance the knowledge and involvement of the QAPI Steering Committee are an important and valuable next step in the evolving continuous quality assurance program.

Stakeholder interviews and focus groups revealed that there are considerable communication opportunities within the QAPI structure and in other forums, i.e., the various county-based committees that are organized around many operational issues, such as court processes, intake to residential care, local service capacity and access, etc. Some of these are new to the reorganized system of care and some are groups that continue to meet as county-based stakeholder groups from the former system of care model. The QAPI model envisioned Quality Assurance Committees operating at each of the Service Areas, however only three of the five planned committees have actually been established.

While the sheer number of invested stakeholders actively participating in committees or groups throughout the state reflects the interest and commitment inherent to improving the child behavioral health system of care, the absence of accurate and useful information is a barrier to success. Key stakeholder interviews reveal that many are frustrated by the absence of information for assessing critical questions important to understanding how effective the system is operating. In the absence of baseline data for comparison, questions about the effectiveness of efforts to increase residential care capacity at all levels, trends in length-of-stay for residential care, and the effectiveness of the strengths and needs assessment tools are among the themes noted when questioned about performance improvement.

As shown on **Table 9** planning occurs in the absence of useful data across all critical areas such as cost factors, utilization rates, child outcomes, and consumer input.

Similarly, key stakeholders express the desire to understand their agencies' performance in the context of like-service providers around the state using standardized data. Beyond pure relativism, broad knowledge of high-performers in certain areas promotes sharing of best practices and collaboration in process and practice improvement. DCBHS's QAPI Program Description and other nationally recognized system of care models recognize the critical

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nature of these two features in the implementation and maintenance of effective systems of care. While key stakeholders interviewed in this study have expressed great interest in successful models and practices employed in other states, attention to developing useful and accurate data about the New Jersey service system may reveal highly effective practices already operating in their own counties.

Both quantitative and qualitative data is necessary to fully develop a continuous quality improvement plan and business culture. DCBHS's QSR reviews have the capacity to bring added value in the form of qualitative data to the understanding of quantitative performance data especially at the local level. To date, information gathered from the initial reviews has been used in limited ways at the local level. However there has been no plan to use aggregate information for statewide planning or to integrate local data with the limited performance outcome data that is currently available. The availability of such a mechanism would support the development of cogent statewide quality improvement action plans that will have relevance to all stakeholders statewide. There are elements of DCBHS's proposed 3-step plan that intend to fill this void, however the details of how case practice issues will be specifically captured in the local systems evaluations and core outcome measures (steps 2 and 3) are not detailed in the current working draft of the plan.

DCBHS maintains a complete unit of Quality Assurance Specialists, each of whom has training and background in program and data analysis. This unit has had involvement with the QSR sites and has assigned responsibility for follow-up and status checks on work plans developed from these reviews.

Information gathered from stakeholder interviews finds that this unit was fully staffed in 2005; however, the unit appears to have been underutilized until recently. Assistance with special case reviews, support to contract compliance staff, and minimal involvement with the QSR process are among the activities reported. The unit was staffed and designed to receive, analyze and report on statewide service data generated from the field. This reporting would include trend analysis to inform decision-makers and actionable recommendations for performance improvement.

DCBHS's 3 step enhancement plan discussed in Section II A of this report will benefit from the availability of this highly qualified unit and the potential of the ABSolute system.

## **Identified Strengths**

1. The QAPI Steering Committee has been active for the past 3 years and includes a broad-based stakeholder membership. Interested and active stakeholders are strengths in the system and a basis upon which effectiveness can be enhanced.
2. Direct service providers appear energized by the potential for expansion and standardization of data-driven performance expectation and increased accountability. Both elements are inherent in the current strategies DCBHS is planning to deploy.
3. DCBHS has a highly qualified and trained Quality Assurance Unit capable of supporting CQI plans and future performance-based system of care.

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## Identified Needs and Recommendations

1. The quality assurance structures have not received sufficient and routine quality data or information to be an effective planning and advisory group. All data available to DCBHS should be available to the committees routinely or through electronic self-service.
2. Any performance standards established in the QAPI Program Description that are adopted by DCBHS and included in provider contracts should have an associated report published routinely and shared with quality assurance entities (along with other relevant stakeholders).
3. QA steering committee reports should be developed separate from meeting minutes and have a formal distribution mechanism.
4. The proposal for DCBHS to co-lead a quality assurance and improvement steering committee is a viable means to develop true collaboration in the planning and execution of the quality assurance and improvement program. A successful demonstration of this with a QA committee would serve as a helpful model for other statewide and county level committees involved in children's behavioral health services.

## Section III: Summary of Implementation Status and Recommendations

Strategic steps for implementing a continuous quality improvement system that were identified in the reform initiative are at various stages of completion at this time. A summary status statement and recommendations regarding key elements to assist with future planning and development are offered below.

### **Key Element 1:** Creating a CQI culture within the Division of Child Behavioral Health Services

Basic quality assurance and improvement structures have been created such as the QAPI Committee Structure. However, this structure is not coherent, lacks focus on quality standards and performance planning and review, and lacks shared accountability for child and family outcomes. These are basic requirements for establishing a CQI culture, or "golden thread," throughout the system of care.

### **Recommendations**

1. DCBHS (in collaboration with state level and community stakeholders) should establish standardized core outcome goals and performance expectations for child and family outcomes.
2. DCBHS should work with its CSA and contracted providers to modify current information system reporting and data gathering procedures to ensure collection and reporting of performance indicators relevant to these outcomes.

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3. DCBHS should ensure that these core outcome and performance standards are included in all service contracts with CMO's, YCM's, FSO's, MRSS, and residential care providers, and; ensure that these contracted providers include the standards in sub-contracts and/or working agreements with other community agencies that offer services and supports to children with mental health problems and their families.
  4. DCBHS should require quality assurance and improvement programs in each service provider agency under contract, and coordinate/integrate those CQI activities with the state's role and functions to maximize the impact of these resources.
  5. DCBHS should ensure that staff training curricula at all levels of the system of care include continuous quality improvement fundamentals and specific goals and expectations regarding child and family outcomes.

**Suggested Resources for Best Practice Models relating to  
Key Element 1:**

- A. The Hawaii Child and Family Mental Health Division has promoted multi-agency coordination and established quality monitoring. Inter-agency monitoring teams perform system and child reviews. Qualitative data is combined with quantitative data used for management briefings and stakeholder feedback (Daleiden & Chorpita, 2005). Hawaii has also been successful in the development of staff training programs with a focus on child and family outcomes and evidence-based practices.
- B. Florida's Department of Children and Family Services has recently developed a *3-tier Integrated Quality Management System* (2005). This model restructured monitoring activities and responsibility for primary quality performance at the service provider level, and redefines state oversight activities in a manner that maximizes efficient use of resources and ensures shared accountability for performance outcomes. Key features of this model include consistent quality assurance monitoring standards and procedures statewide in the context of local application. A collaborative state and local provider workgroup approach was used to develop and refine this model and was instrumental in maximizing stakeholder input and buy-in.
- C. The Utah Division of Child and Family Services' quality assurance system is cited for clear outcomes and indicators that are included in the state's strategic plan (NCWRCOI, 2002). *Utah's Performance Milestone Plan* (Utah Division of Child and Family Services, 1999) provides a detailed performance plan outline that includes development of priority focus areas, accountability structures, trend data analysis, and monitoring processes.

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## **Key Element2:** Engage community stakeholders in the CQI process to strengthen partnerships in support of improved outcomes

DCBHS has made progress in reaching out to community stakeholders and creating opportunities to participate in the planning and on-going review of the system of care. The QAPI Committee process is a good example of a stakeholder-based structure that has the potential of supporting the system of care and promoting positive outcomes for children and families even though its effectiveness has been hampered by issues identified above.

The QSR process also is a mechanism where community stakeholders have the opportunity to learn about how their local system is functioning and participate in developing strategies for improving practice and ultimately outcomes for children and families. Case practice reviews provide added value to performance data analysis in the process of understanding systems' strengths and weaknesses.

### **Recommendations**

1. DCBHS should co-lead a QA steering committee under a revised Mission and Philosophy that is enhanced to include true public/provider collaboration. Mechanisms, such as county-based sub-committees, should be considered to promote this model throughout the system of care. This would be consistent with the one of the core design elements of the system structure found in the QAPI Program Description: "Collaboration Across Child Service Systems" (DCBHS, 2005).
2. DCBHS should ensure engagement of community stakeholders in local quality assurance and improvement activities, especially the Local System of care Assessments and Method Assessments that are in DCBHS's 3-step implementation process discussed in Section II A. Substantive participation in the planning and design of these mechanisms is highly recommended in addition to participating in the actual assessment activities.

### **Suggested Resources for Best Practice Models relating to Key Element 2:**

- A. The Utah Division of Child and Family Services is recognized for extensive work with external stakeholders in continuous quality improvement. Under its Performance Milestone Plan, Utah has established Regional and State Quality Improvement Committees. Along with management at the state and county level, these committees work to review information on quality and identify needed improvements (NCWRCOI, 2002).
- B. The Hawaii Child and Family Mental Health Division Quality Assurance and Improvement Program (2005a) is a statewide system and addresses all services and service delivery sites. Local-level implementation of the QAIP considers local context while continuing to reflect a consistent statewide program for quality assurance and improvement.

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### **Key Element 3: Develop and apply new tools for collecting and reporting outcome information**

DCBHS has acquired, through the CSA, a powerful tool with the ABSolute information system that has the potential to meet the data gathering and reporting requirements of a robust continuous quality improvement program.

The Strengths and Needs Assessment is a standardized tool used to inform service eligibility decisions, initial service level assignment, and on-going assessments of progress against service plan goals and objectives.

### **Recommendations**

1. DCBHS, with input from service providers, should review and assess current reports and information generated from ABSolute and develop report content and formats that are consistent with outcome and performance standards. This review should also include an assessment of customer input generated from CSA focus groups to ensure that user concerns and suggestions have been addressed.
2. DCBHS needs to establish clear, consistent, and measurable indicators for all child and family outcome goals that are established, including overall goals such as maintaining children at home, in school, and avoiding delinquent behavior. The current method used in some provider contracts that describes “milestones” and “assumptions” is not effective for measuring such outcomes.

A monitoring and review tool for contract monitoring should be developed to standardize data collection and reporting of performance.

### **Suggested Resources for Best Practice Models relating to Key Element 3:**

- A. Numerous publications have recognized the Dawn Project (Marion County, Indiana) and Wraparound Milwaukee for effective use of data and technology. The projects provide integrated cost and service delivery data to service partners that enable them to assess both the costs and effectiveness of their service delivery choices (Hornberger, Martin, & Collins, 2006).



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## **Key Element 4: Create a performance-based contracting system connected to the commitments and benchmarks of The Plan**

DCBHS has established some elements of performance-based contracts including the identification of performance targets in CMO and MRSS contracts. The ability to enhance the quality and integrity of performance-based contracts is contingent on several issues identified above, especially the gathering and reporting of baseline and on-going performance data, data analysis, performance monitoring, and inclusion of measurable process/practice and family outcome standards in all service contracts.

### **Recommendations**

1. DCBHS should develop a plan and timeline to establish service performance standards and amend service providers' contracts to include these standards and clear standards for accountability. All performance standards should have established targets included in the contract to ensure clear expectations.
2. DCBHS should establish standards and performance expectations for timely and accurate data entry by provider staff since data integrity underpins the entire quality assurance system. These standards must be included in all service contracts where data entry by staff is required.
3. DCBHS should develop a plan for incentives and/or penalties for non-compliance with critical process/practice performance standards, such as data accuracy.

### **Suggested Resources for Best Practice Models relating to Key Element 4:**

- A. The Hawaii Child and Family Mental Health Division has established goals and objectives which extend to maintenance of qualified service providers in addition to quality of care in direct service provision as described in the *Quality Assessment and Performance Improvement Work Plan (2005b)*. Outcomes and indicators are appropriate for performance based contracting and systemic monitoring.
- B. In 2000, An Innovations in American Government Award was received by The State of Illinois Department of Children and Family Services. Illinois initially overhauled its placement services contracts using a performance based contracting approach and realized a dramatic improvement in outcomes for children (Harvard University, 2006). Performance-based contracting has extended through the service delivery system since that time. ■



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## Chapter 3: The Assessment Process for New Jersey's Children's Behavioral Health System

### Research Question:

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- Is the assessment process for identifying the mental health needs of children and their families consistent with national best practices, and is the process effectively implemented?
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### Introduction

The *Children's Initiative Concept Paper* (State of New Jersey, 2000) envisioned the use of a uniform, statewide assessment tool. The assessment tools New Jersey adopted were embedded in an outcomes management approach derived from the work of Dr. John S. Lyons. Dr. Lyons' Total Clinical Outcomes Management process held that "all decisions at all levels of the system should be informed by knowledge of the needs and strengths of the child and family." (Lyons, 2002, p. 127). Over the past six years, in consultation with Dr. Lyons, New Jersey has worked to implement this assessment and outcomes management approach for a number of purposes within the children's behavioral health system.

The assessment process in New Jersey is formally known as the Information Management and Decision Support (IMDS) system. The actual assessment instruments used as a part of this system are known as IMDS tools or IMDS assessments. These tools consist of the Strengths and Needs Assessment (SNA) and several permutations used in different settings. These tools are also sometimes referred to as the CANS assessments, based on their original name, the Child and Adolescent Needs and Strengths (CANS).

This chapter of the Independent Assessment considers the overall design of the IMDS approach and its appropriateness for New Jersey's goals. This chapter describes key aspects of implementation and current practice and identifies areas of strength and need in light of the data gathered in New Jersey and current thinking regarding best practices in children's behavioral health. (Note: The Independent Assessment did not review the use of other (non-IMDS) instruments and processes being used in New Jersey for screening, diagnostic, or evaluation purposes.)

There is significant overlap between this and other questions posed in the Independent Assessment. In particular, a full review of the assessment and outcomes management process, as it was conceived of in New Jersey, must consider:

- Issues related to the target population definition and the development of clinical guidelines (Chapter 5: Service Array)

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- An understanding of the manner and extent to which the data are used to inform quality improvement efforts and overall system reform including the performance of the ABSolute system, data quality, effectiveness of reporting to providers for management purposes, etc. (Chapter 2: Quality Assurance, and Chapter 1: Governance)
  - The role of the CSA vis-à-vis assessment, access, level of care determination, etc. (CSA Role, Chapter 2)

## Background

### Principles of Assessment in a System of Care<sup>2</sup>

As part of the accountability movement in the delivery of mental health services for children, attention is increasingly focused on the accurate assessment of consumer functioning and on the development and use of clinical guidelines and outcome measurement processes. According to the Health Care Reform Tracking Project (HC RTP), 94% of managed care carve-outs and integrated managed care behavioral health systems are using “standardized clinical care guidelines and decision-making criteria specific to children’s behavioral health.” (Pires and Grimes, 2006).

Outcome measurement serves a number of purposes for the service system, including documenting the status of children entering the system, aiding the development of individualized plans of service, determining levels of care and treatment, providing feedback on status to youth and families, demonstrating the effectiveness of services; assessing the quality of services and consumer satisfaction; planning for organizational and system needs; determining the case mix within the organization; and, establishing systems accountability regarding service expenditures, the quality of service delivery, and the success of programs or programmatic service elements.

A number of instruments and assessment processes have been promulgated in the last decade for use in the public mental health system. These assessment processes have ranged from those limited to a single question anchored with behavioral descriptors to multiple level instruments based in psychometric theory. Instrumentation has varied from measures designed to assess a single construct such as depression, daily functioning skills, or risk of harm, to those designed to give a relatively complete description of the status, functioning, and needs of the child across the major domains of concern in a comprehensive system of mental health care.

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2 This discussion of Principles of Assessment in a system of care includes material from an in press monograph from the Research and Training Center for Children’s Mental Health, University of South Florida, Louis de la Parte Mental Health Institute. Please do not quote without permission. It is also informed by Health Care Reform Tracking Project (HC RTP) report on Clinical Decision Making (Pires and Grimes, 2006).

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Assessment is an integral part of any outcomes management and decision-support process and although the choice and use of assessment tools and processes differs for each system of care, some consensus is beginning to emerge regarding principles and characteristics of effective approaches:

- 1) The assessment process should be designed in alignment with underlying values, goals and desired outcomes.
- 2) The assessment process must address multiple domains of the child's functioning such as clinical status, level of functioning, and quality of life. Further, the assessment process may need to address multiple spheres of the child's experience such as home, school, and social and interpersonal relations. A third arena of concern may include issues associated with individual and family strengths and resources, co-morbidity, risk of harm to self or others, and cooperation with treatment.
- 3) The assessment process should include a thorough assessment of child and family strengths structured to inform treatment planning that will utilize and build on strengths.
- 4) The assessment process (the instruments, the methods employed for gathering information, and the interpretation of findings) should be informed by and appropriate to the child and family's language, culture, education level, religion, family composition, etc.
- 5) Family members and youth should be involved in all aspects of the assessment process. This includes families and youth providing information needed to complete the assessments, receiving regular feedback about their progress, shaping treatment plan changes, and participating at a policy level as assessment data are used to guide the development of the system of care.
- 6) The assessment process must balance the need for a comprehensive assessment with efficiency, ease of use, ease of training, and ease of interpretability. Ease of use, training, and interpretability are required because of the exigencies of state mental health services including high turnover, extensive use of bachelor level staff, and limited support resources.
- 7) The outcomes assessment must often serve multiple purposes, as described above, such that it may measure at the child and family level: a) individual functional status, b) service need, and c) improvement over time; while also serving to measure and document the quality, appropriateness, and effectiveness of the program of services and the quality and competence of the service provider.
- 8) The assessment process should facilitate access to the appropriate type and amount of service and appropriate access (Pires and Grimes, 2006)
- 9) Promote consistency and equity in service provision (Pires and Grimes, 2006).
- 10) Provide objective rationales for service authorization decisions (Pires and Grimes, 2006).

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- 11) Ensure that the assessment process supports the clinical integrity and authority of child and family teams in the context of other mechanisms that may be in place for access and authorization.
  - 12) The assessment process should be coordinated with the quality assurance/quality improvement process so as to foster accountability, alignment with system goals, and in a manner that informs the adoption of evidence-based and effective practices (Grimes and Pires, 2006).
  - 13) The assessment process must be sensitive to the needs and priorities of multiple stakeholders including clinicians, administrative staff, consumers themselves, family members, and those responsible for program and service oversight. When multiple systems are involved, the assessment and reporting requirements should be streamlined and coordinated.
  - 14) The assessment process must be meaningfully embedded in a management information system that provides feedback to stakeholders and other information consumers. For effective use of the information to occur, this requires commitment from both administrative and line staff, and investment in the information system infrastructure. Reports should be designed with the input of stakeholders.
  - 15) Adequate resources should be available to design and sustain the MIS systems needed to support the assessment process, including staff at various levels with the capacity to nurture the development of a culture that effectively utilizes data.
  - 16) The management information system infrastructure must address and solve a number of implementation issues including developing initial and ongoing training protocols for those conducting and using the assessment instrument, a process that provides timely feedback to various consumers of the assessment process, and a means of ensuring the continued reliability and stability of the assessment process.
  - 17) The assessment process must be defensible from a psychometric standpoint with evidence of reliability and validity for the intended purposes, including both traditional notions of reliability and validity as well as offering face validity to users and cultural sensitivity and relevance for children and families.
  - 18) The assessment process should be accessible and transparent to users and available to stakeholders and critics of the system. This includes clinical guidelines, information on exceptions and why those occurred as well as aggregate outcome findings, etc.

These principles and characteristics don't add up to a prescribed, universal approach to assessment and outcomes management, but they serve as important criteria against which one can take stock of the design and implementation status of any assessment and outcomes management system.

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## **Child and Adolescent Needs and Strengths (CANS)**

According to Lyons, a uniform methodological approach allows for the development of a series of locally constructed decision support tools commonly referred to as the Child & Adolescent Needs and Strengths (CANS) (Lyons et al. 2003). These tools can guide service delivery for children with mental health needs, developmental disabilities, and issues of sexual development, juvenile justice involvement and child welfare involvement. The tools are designed to provide a structured assessment of children along a set of dimensions relevant to service planning and decision making with the primary objectives of permanency, safety, and improved quality of life.

The CANS assessment process is envisioned to be a communication strategy, creating a 'common language' and integrating information across child serving systems. CANS provides information regarding the child and family's service needs for use during system planning and/or quality assurance monitoring. Due to its modular design the tool can be adapted for local applications without jeopardizing its psychometric properties. Evidence regarding the reliability and validity of CANS is growing (Anderson et al. 2003; Lyons et al. 2003; Rautkis and Hdalio, 2001; Winters et al. 2005). CANS is used for purposes similar to New Jersey in a number of states and localities, including New York, Illinois, Philadelphia, and Massachusetts.

Dr. Lyons, along with Children's Initiative and UMDNJ staff, gathered input from stakeholders across New Jersey -- including families, providers, and public officials — to modify the Child and Adolescent Strength and Needs Assessment (CANS) instrument(s) to create the Strengths and Needs Assessment (SNA) and related tools, which are embedded in New Jersey's Information Management and Decision Support (IMDS) system.

## **Assessed Strengths, Needs and Recommended Improvement Opportunities**

This section a) describes the design of the IMDS tools (assessments) and system; b) describes the application of these tools to accomplish key decision-making and outcomes management functions; c) describes IMDS training, certification and technical assistance; and, d.) summarizes IMDS implementation status and key recommendations.

### **A. IMDS System and Tools: Design**

#### **Background and Current Status**

The New Jersey System of Care Concept Paper (State of New Jersey, 2000) set forth a goal of establishing a "single point of entry" and a "common screening and assessment process used across the various DHS child serving entities [as] the basis for determining service needs" (State of New Jersey, 2000). The new system would "install utilization management methodologies that assure rapid access to services and care coordination to ensure

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comprehensive treatment planning, active family involvement, clinical innovation, and provider accountability to treatment goals and objectives through a Contracted Systems Administrator (CSA). There will be no incentive for the CSA to restrict care for children and youth.” (State of New Jersey, 2000)

New Jersey policymakers’ objectives (Caliwan, 2005) anticipated that the IMDS assessment tools and processes would assist:

- Planners and quality assurance process to monitor quality, inform the sizing of the system, and document improvement;
- Children and families to understand needs, document improvement and self-advocate;
- Providers and care managers to guide service planning, supervise and train, monitor child progress, and to collaborate; and,
- Funders and administrators to ensure limited resources are appropriately allocated and expended, and to plan for and prepare budgets.

## **IMDS Assessment Tools<sup>3</sup>**

The following assessment tools are in use in New Jersey:

- Crisis Assessment Tool (CAT) is used by Mobile Response and Stabilization Service (MRSS) providers to support decision making about children whose behavior places them at risk of being removed from their homes or of placement disruption. This instrument is intended to allow for rapid and consistent communication of the needs of children experiencing a crisis that threatens their safety or well-being or the safety of the community.
- Needs Assessment (NA) is used by system partners to screen for service need and to determine initial level of care. It is intended to be completed by individuals who are directly involved with the referral. The assessment tool serves as a template to consistently integrate information about the needs of the child and family to support decision making, and to ensure that the child and family receive appropriate services. The Contracted Services Administrator (CSA) requires both a needs assessment and a recent evaluation for referral of a child for services.
- Strengths and Needs Assessment (SNA) is a comprehensive service planning assessment for use with children and families receiving the most intensive services (CMO, YCM, and residential) and is administered at 30-day intervals while a child is receiving services and at discharge. The SNA acts as a vehicle to organize the information already gathered from the child and family and to support the planning process regarding decisions about meeting the needs of the child and family as well as identifying and building on strengths.
- The Family Assessment and Support Tool (FAST) is not yet in use although training

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3 Description of the assessment tools was compiled from IMDS manuals and an IMDS glossary



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and certification protocols are ready. The FAST Tool is designed to gather information about *family circumstances* and is based on the theory that the family is both a system of relationships and a set of individuals.

The items on all tools each have four levels. These four levels have anchored definitions which are designed to translate into 'action' levels:

- 0** no evidence, no need for action
- 1** watchful waiting/prevention
- 2** action (need is notably interfering in the life of child and/or family and something needs to be done).
- 3** Immediate or intensive action (need poses an immediate safety concern or is a priority for intervention)

## Findings

New Jersey was one of the first states to begin to implement a statewide, common assessment and outcomes management process. With that decision came tremendous potential to use data to make better decisions for individual children, refine and improve the effectiveness of services and engage in meaningful, informed systemic changes. The design is ambitious and is consistent with national best practices in many respects. It is important to note that for all states, assessment, clinical guidelines, level of care determination and outcomes management approaches should be (and are) continually evolving as systems of care mature and as outcomes data and practitioner experience feed back into the design.

While the Independent Assessment staff heard specific concerns about the IMDS assessment tools themselves, it is important to distinguish these from concerns about the way the tools are used or the Contracted Services Administrator (CSA) data system, ABSolute. Providers reported many technical challenges and confusion with the launching of ABSolute and the initiation of the referral/authorization process. When asked about the tools, focus group participants cited on-going difficulties with the user-friendliness of ABSolute, authorization delays, and what they characterized as 'arbitrary decision-making' by the CSA. These technical problems interfere with access and impede movement toward a system culture based on information.

Themes from stakeholder interviews and focus groups indicate that because the IMDS tools were closely associated with the initiation of the CSA which was resisted in concept by many, there was a *spill-over* indictment of the tools themselves. With respect to the IMDS design and tools, the Independent Assessment staff heard a range of opinions, which taken together might best be characterized as guarded optimism. The overwhelming sentiment was frustration that the IMDS system had not been fully implemented and that providers didn't have the information they needed for management purposes or to pass judgment on the utility of the tools. While there were some specific concerns (outlined below) there was not an outcry to switch tools or abandon the process altogether. There was a palpable interest in using the data to inform practice.



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## Identified Strengths of the IMDS Process and Tools

- There is tremendous value in having statewide, uniform assessment tools and an IMDS process. Used wisely, these processes can balance individual responses with objectivity and inform decision-making with best-practice guidance. Concerns about bias can be evaluated, documented, and corrective action monitored. The data can inform quality assurance work which in turn should improve services to children and families. Comparative analyses can shed light on what contributed to positive outcomes for the purposes of replication. The data are transparent and can ground resource allocation, contract decision-making, and other politically-charged decision-making.
- Many, including family members, describe the initial planning process for the assessment component of the reform as broadly inclusive. This opportunity for input very likely resulted in better tools, better understanding of the purpose of the tools, and greater buy-in.
- The choice of the CANS assessment tools was consistent with goals of the Children's Initiative and was well-suited to New Jersey's high need for flexibility and a common language to effectively serve youth in all child serving systems.
- CANS' genuine consideration of strengths distinguishes it from other assessment tools and is consistent with the values espoused by New Jersey. The need to routinely respond to strengths questions on the assessment instruments may prompt treatment planning that draws upon and develops strengths as a means of improving outcomes and supporting recovery.
- The research evidence supporting the validity and reliability of CANS is growing (Winters, Collett, and Myers, 2005). IMDS meets (or has the potential to meet when fully implemented) many of the assessment promising practice criteria listed earlier.
- The IMDS tools are designed to be used by non-clinicians as well as clinicians. New Jersey has trained staff from all system partner agencies in an effort to facilitate communication and improve the identification of children's mental health treatment needs. This broad training sends the message that assessing for mental health needs is viewed as everyone's responsibility and that knowing/finding the answers to important assessment questions is the responsibility of not only 'mental health' providers, but all providers.

## Identified Challenges of IMDS Process and Tools

- A number of concerns were expressed about the clinical relevance of the IMDS tools which were described by some as being 'not clinically sophisticated', 'rudimentary', and 'not capable of yielding accurate psychiatric diagnoses'. CANS is not a traditional diagnostic tool and efforts to use it as one will be perpetually frustrating. The instrument is not designed to be used in isolation. There is a role for clinical expertise which is consistent with and builds upon the strengths and needs identified by the CANS. The role of clinician judgment needs to be clarified so the dynamic can be shifted away from the unhelpful CANS vs. clinician dichotomy.

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- User skepticism, where it exists, is exacerbated by the fact that the data are not being used on a regular, widespread basis, giving users little opportunity to actually assess its validity and utility. Providers do not feel that they have been able to see for themselves whether the data make sense. In addition, they feel that their requests for certain types of reports have not been honored.
  - Trainers report that those with clinical training and providers in juvenile justice and DYFS often have difficulty using these assessment tools (e.g., probation workers find it difficult to trust child and parent-provided information and DYFS' mandate to assure child safety in a prospective manner makes it difficult for them to assess based only on the past 30 days). Although the ability of non-mental health clinicians to use this instrument is viewed by many as a strength, focus groups participants reported that clinicians felt that this was 'risky.' DYFS and Juvenile Justice administrators report that many of their staff are uncomfortable with making judgments 'outside their area of expertise' and prefer not to conduct these assessments.
  - Comments from stakeholder interviews suggest the need for improved coordination between the University Behavioral Healthcare's Behavioral Research and Training Institute of the University of Medicine and Dentistry of New Jersey (UBHC-BRTI) trainers, the CSA and DCBHS each of whom plays a role in the assessment and outcomes management process. As a group, these players need to seek regular user input and develop a coordinated response and course of action.
  - Focus group participants reported that changes in the assessment and authorization process have not been communicated in a coherent way.
  - Family member interviews indicate that family understanding of and involvement in the assessment process is inconsistent. In interviews and focus groups, providers and family members alike expressed a need for more guidance about how to best use these tools with families.
  - Comments throughout the Independent Assessment speak to tensions between the values and practices of wraparound and the imperative to make rational, informed decisions using standard decision-making protocols, algorithms or gatekeeping functions. It is the perception of some that 'rigidly applied' level of care determination interferes with getting the right services to the child and family. DYFS participants in particular voiced this concern, but so did others. Processes that make authority for clinical decision-making more remote from the child and family and their providers (e.g., a statewide CSA) heighten this tension. The CSA and others provided a number of examples where specific situations or needs were addressed in highly flexible, family-friendly ways; the same solutions are crafted on a daily basis at the local level. The system needs to explore ways to make this flexibility standard within a framework that uses data to inform all decisions for improved, equitable results.
  - The use of the same assessment tools for multiple purposes may create conflicts of interest. For example, the deliberate use of assessment scores to gain access to levels of care could compromise objectivity in treatment planning decisions. Further, there is a risk of bias when provider-measured changes in child outcomes are used to measure

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provider performance. This is not unique to CANS or to New Jersey, but there are few mechanisms in place to monitor the integrity of the assessments and decision-making process.

- The power of the analyses that might be done to better understand the dynamics of the system is somewhat limited because there are so many children for whom data collection is not required including those receiving inpatient care and children in alternative juvenile beds.
- The availability of Intensive In-Home Care (IIC) assessors allows system partners and others to not fully engage in the assessment process. This may be necessary until sufficient numbers are trained and Superusers are in place, but it is not ideal because it compromises the communication of the tools and allows system partners to continue in their belief that it is not their responsibility to know about the mental health needs and strengths of the children in their care.

## **B. IMDS System and Tools: Applications**

### **Introduction**

There are three fundamental applications for the IMDS tools. The findings presented in this chapter pertain, primarily, to decision support. Generally speaking, the data have not been used thus far in New Jersey for quality improvement and outcome monitoring in a systemic and sustained way.

- Decision support: Ensure that decisions are clinically appropriate and made consistently at key points in the service delivery process (e.g., access, level of care determination, service planning, discharge decision-making).
- Quality improvement: Ensure that potentially effective interventions are provided when indicated and that needs are assessed accurately and in a timely fashion. Monitor for fidelity of treatment model and assessment process, system of care principles (strengths-based, family-driven, multi-system), and effectiveness.
- Outcome monitoring: Inform clinicians, administrators and evaluators about the impact of the interventions or programs (child, program and system-level outcomes and indicators), report cards and feedback to planning.

### **Background and Current Status**

#### **System Access and the Assessment Process**

The Needs Assessment is (with a few exceptions) required for referral to services accessed through the CSA. The Needs Assessment can be completed by community providers (e.g., intensive outpatient, clinic, DYFS workers, probation officers, care managers, etc.) who have been certified in its use. If the provider cannot conduct the Needs Assessment or if the child does not have a recent clinical evaluation (also required), the CSA can arrange for these to be done by a masters-level licensed Intensive In-home Clinician (IIC).

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Youth or families can self-refer by calling the CSA. Families can choose to work with a provider of their choice or the CSA can make a recommendation from a database of certified assessors. The CSA sets up a three way conference call to make the connection between the family and the provider to schedule an appointment.

Needs assessments are required to be done within 14 days of referral and these are filed with the CSA using the ABSolute system directly or via Autofax. The Autofax process was devised by the CSA in response to the concerns of providers (particularly DYFS) who either did not have computer access or who were not comfortable using ABSolute. A number of sources reported that it often takes longer than 14 days to get these assessments done. The CSA indicated that corrective action plans have been put in place with specific providers to rectify this problem.

The process for accessing residential care is different. For this, the Needs Assessment is used in conjunction with clinical evaluations and a telephonic interview with a CSA clinical care coordinator who interviews the referring provider to obtain a clinical basis for assessment scores. The process takes about one hour and the CSA states that it is looking for consistency between the needs assessment, other evaluations and treatment plan goals before authorizing residential care. Historically, providers made these arrangements for residential care directly, within established networks and without CSA involvement. This change has not been well-received by front-line workers. There have been some problems with the assignment process (beds not available as indicated, inaccurate information regarding the type of child served, etc.). A new process known as Residential Bed Tracking II will be instituted in the fall of 2006 and the CSA is currently providing training to users. This change in procedure is designed to improve accuracy of bed-availability information; make the referral process more timely; and assure the best match between provider expertise, programming, family wishes, and the child's needs.

Once a child is enrolled in a CMO, YCM or residential services, the more comprehensive Strengths and Needs Assessment (SNA) is completed and updated as a requirement of reauthorization. While there are discharge criteria in the DCBHS Clinical Guidelines, various sources indicated that these are followed inconsistently. Assessment scores are reportedly not considered in determining a child's readiness for discharge or transition to less intensive services. A theme throughout stakeholder interviews and focus groups was that discharge planning and oversight of the discharge process was inadequate, allowing children to stay in higher levels of care (or any service for that matter) that might not be in the child's best interests.

### **Level of Care Determination**

The IMDS assessment tools can be used in conjunction with decision support algorithms. New Jersey developed algorithms in consultation with Dr. John Lyons, using a formalized process. These algorithms are intended to be used to support rational decision-making by using criteria that describe the clinical characteristics of a child and family to inform the assignment of children to the most appropriate type and level/intensity of care. Algorithms look at patterns within the assessment ratings to suggest, in this

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case, assignment to a certain level of case management or to justify a decision to seek residential services. The algorithms consider both needs and potentially mitigating strengths. For example, there might be different level of care indications for two children with similar clinical needs, but with different patterns of family strengths.<sup>4</sup> In a fully implemented outcomes management process, algorithms are refined as the service system matures and outcome data provide feedback on what kinds of services are most effective for children and families presenting with different strengths and needs. In New Jersey, this type of analysis has only occurred on a limited basis, although algorithms have been revised somewhat based on an analysis of assessment data and user feedback. This kind of thinking will be a critical aspect of implementing evidenced-based practices where the assessment process is used to inform decisions about which services are most likely to be effective for which children.

### **Informing Treatment Planning and Promoting Service Coordination**

There are several types of treatment plans used in New Jersey – among them, the Individual Crisis Plan (ICP), Individual Service Plan (ISP), and the Joint Care Review (JCR). The IMDS tools are designed to inform the development of treatment plans.

The extent to which providers see the two as linked is hard to gauge, and while the survey responses suggest that the assessments provide a framework for treatment planning, focus group participants and others indicated that many providers were not fully utilizing the assessments for either treatment planning or as a tool for supervision.

As noted earlier, the full Strengths and Needs Assessment (SNA) is completed for children referred to CMO, YCM, or Residential Services with the purpose of informing the development of the Individualized Service Plan. In order to complete the SNA (initially and ongoing), the care/case manager would need to speak with family members, community members and other service providers who are involved with the child. For the IMDS tools to serve the communication function they are intended to serve, the care/case manager needs to embrace this intent and grow in understanding of how the tool can be powerful in this way. Based on comments heard throughout the assessment process, this is not yet occurring except in unusual circumstances. Stakeholders did feel that the tools were helping to develop a common language which is an important step.

Some, but not all, providers have access to the ISP and the assessments through ABSolute. Intensive In-home Clinicians and Behavioral Assistance providers have no access to this system at this time. Those who do have access cite the common case record as a positive development.

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4 For more information on the development of algorithms and on the conceptual framework behind New Jersey's IMDS system, see Lyons, John S., Chapter 5: The Measurement and Management of Outcomes in A Total Clinical Outcomes Approach, in *Redressing the Emperor: Improving our Children's Public Mental Health Systems*, pp. 127–177.

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## Quality Improvement

This issue is addressed in detail in Chapter 2 in reference to processes to use data to monitor and improve the integrity and quality of services. Little has been done to formally assess the integrity of the assessment process itself (e.g., to hold providers accountable for the accuracy and integrity of their assessments, track adherence to timeframes for data submission and reporting).

## Outcomes Monitoring

Data have been used to inform the development of algorithms (Lyons, 2003a), to better understand the way that services are being used (Lyons, 2003b), to begin to look at outcomes (CMO Outcomes Report, no date), and to inform the System Sizing Methodology (Marics et al. 2006). Recently, the CSA began to look at assessment data to better understand the unique needs of children with developmental disabilities being referred for services. These reports are excellent examples of the potential for this type of analysis, but this type of analysis is not routine, and it is neither informed by nor regularly disseminated to and discussed with providers.

## Findings

The majority of respondents to the web-based survey found the assessments beneficial for many key functions. For example, over 60% of respondents either agreed or strongly agreed that the assessments were helpful for level of care decision-making, treatment planning, and in creating a cross-system common language. At the same time, there is a significant number of focus group participants who indicated that they did not find the SNA helpful, that they use a supplemental instrument(s) to gather the data they ‘really need’ (increasing the data collection burden for workers and families), and they expressed concerns that the quality of their staff members’ data collection was poor. These comments spoke to the importance of supervisors buying in and having sufficient expertise and training to support and coach their workers in how to get the most out of these tools.

Responses about functions that were more dependent on using the system’s ability to produce reports and feed data back to providers for monitoring were somewhat less favorable. In a series of questions about the quality of data and user-friendliness of the ABSolute data system, responses indicate that while this system is working for some, there are a significant number of users who are still struggling. Many respondents questioned the quality of the data (41%) and over half (56%) reported that data reports were not timely and that the format in which they were presented was not useful.

Focus group discussions and structured interviews indicate that there is some confusion about how the algorithms are used by the CSA and an oft-expressed concern that the algorithms are applied too rigidly, resulting in service denials. This is a particular concern with respect to DYFS children although the Independent Assessment was unable to fully evaluate patterns of service denial.



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In addition, a few focus group participants referred to triage forms that the CSA kept ‘secret’ from providers to prevent them from gaming the system by manipulating Needs Assessment scores to gain access to certain services – a practice many admit to doing. This concern, whether accurate or not, speaks to the perceived lack of transparency regarding the protocols and patterns of service approval/denial. There is a “disconnect” between the CSA and local care managers and providers.

## **Identified Strengths of the Application of IMDS Process and Tools**

- Without more analysis of the administrative data, it is not possible to comment on whether this use of a standard assessment in the CSA context is resulting in better resource allocation or outcomes, but a majority of survey respondents agree or strongly agree (66%) that the assessments provide helpful guidance for level of care determination. (Note: there were relatively few DYFS or juvenile justice attorney survey respondents).
- Several respondents reported that the assessments have created a common language for describing needs and strengths and for treatment planning among system partners in their community.
- Access to a common case record and previous assessments has the potential to improve continuity of care as children transition to new levels of care.
- A number of senior managers in state government reported that youth in detention centers and those served by DYFS are more likely to receive assessments and mental health services than in the past.

## **Identified Challenges of the Application of IMDS Process and Tools**

- There is a great deal of confusion and misinformation regarding how clinical guidelines, IMDS algorithms, evaluations, and other information factor into the CSA’s authorization process.
- Some providers indicated that the assessment/access process does not function well when a child has specialized treatment needs and/or dual diagnoses. They feel that there is insufficient understanding of these issues on the part of the CSA care coordinators and that the system access protocols make it difficult to obtain appropriate services for these children. By the same token, the CSA faces significant challenges trying to determine eligibility and coordinate care for these children in the absence of clear guidelines and cross-agency planning processes at the state level.
- A number of sources reported that in order to access the system (or continue a child at a particular level of care), providers were ‘gaming’ the system by skewing assessment ratings to qualify a child who ‘really needs the service, but might not qualify.’ This was reported by family members, the CSA, providers and others.
- DYFS and the Juvenile Justice Commission (JJC) find the assessment process adds



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stress. DYFS supervisors report that some workers don't have sufficient understanding of behavioral health or of the access process. Some respondents found that the access criteria are 'arbitrary' and 'rigid.'

- Significant capacity and 'case flow' problems mean that the algorithms may 'recommend' levels of care that are at capacity (as in the assignment of overflow CMO children to YCM).
- The use of the SNA to inform the development of and changes to the treatment plan is inconsistent. This perceived disconnect limits the value of the assessment and providers get less return or benefit for the time they spend completing the assessment.
- FSO representatives stated that it is common for families to not be involved in the assessment or treatment planning process. We were not able to gauge the extent of this problem, but several providers reported that they were not clear how to gather information from families in a conversational way without 'subjecting' them to the full assessment.
- Because data feedback and routine reporting have not worked as planned, some providers seem to be 'going through the motions' of the assessment process.

## **C. IMDS Training, Certification and Technical Assistance for the Assessment Process**

### **Background and Current Status**

All system of care training and technical assistance, including training and certification on the use of the IMDS tools is managed under a contract between DCBHS and the University Behavioral Healthcare's Behavioral Research and Training Institute of the University of Medicine and Dentistry of New Jersey (UBHC-BRTI). Effective July 1, 2006, the training schedule has been reduced while the state issues a new RFP for this training contract.

According to the most recent annual report by UBHC-BRTI (2006), there are over 2300 certified IMDS assessors (~ 146 in Crisis Assessment and others in the Needs and/or Strengths and Needs Assessment). In the past year, over 1,500 individuals participated in IMDS training. Also in the past year, customized training was provided for YCM workers and for DYFS workers (held by request at DYFS offices).

Distance Learning CDs were created and over 272 CDs were distributed. These were developed for out-of-state residential providers, for use as a refresher course, and for use in-between live training events. Training managers prefer in-person training because participants can discuss vignettes and responses with one another and gain a greater depth of understanding in doing so.

Practice vignettes and certifying tests are completed on-line. An inter-rater reliability rate of at least .70 is required for certification. There is not currently a recertification requirement. A

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number of other states are in the process of instituting recertification requirements to ensure assessors maintain high rates of reliability. UBHC-BRTI staff has recommended re-certification every two years and has worked to ready that process although it has not yet been approved.

In spite of high numbers of newly trained assessors, DYFS reports that many of their offices have too few staff certified in the Needs Assessment. They report that their staff has difficulty passing the certification exam, that they prefer not to conduct the assessments, and that they lose those who are certified to high rates of turnover. Both DYFS and JJC report that conducting the assessment is very time consuming for already busy caseworkers. One DYFS administrator noted that if it is too much work or too complicated to get an assessment and authorization for services, some workers simply won't bother and therefore the child may not get services.

Early in the reform process, more out-of-state consultant trainers were used and initially John Lyons conducted many of the trainings himself. Now, UBHC-BRTI staff members and a project manager conduct the majority of trainings themselves. The Independent Assessment was not able to look at either the effectiveness of or satisfaction with training in a systematic way, but reportedly training is consistently well-attended. Continuing education social work credits are offered.

UBHC-BRTI assessment training, the CSA training on the process of making a referral and use of ABSolute, and communication on DCBHS policies have not been planned and delivered with sufficient coordination. The CSA at first underestimated the need for required training in the use of ABSolute and the process of making referrals and obtaining authorization. There is more attention being paid now, in the roll-out of the new Resibed II tracking system, to the importance of face-to-face training in any new process that the CSA introduces.

According to UBCH-BRTI, on-site technical assistance is provided as requested (or when DCBHS staff identify an area of concern) and providers are encouraged to call with questions. In 2005-2006, UBHC-BRTI staff fielded over 1,100 phone and email technical assistance requests for IMDS coaching and technical assistance related to web-based certification.

UBHC-BRTI developed a "Superuser" model, in order to build community provider capacity to deliver IMDS Tools assessments to children and youth that are being referred into the system of care. This is a two day training process that provides train-the-trainer concepts and in-depth reviews of the IMDS process, in order to support one or two Supervisory level staff from each CMO and YCM to become more reliable in the use of the tool and able to use the CD assisted training tools to train other staff within their own agency in the Strengths & Needs Assessment. To date, 35 Superusers have been trained. In spite of the resources of UBHC-BRTI staff and the availability of Superusers, 33% of survey respondents indicated that case-specific assessment consultation was either not available or that they were not sure of the availability.

Quarterly meetings are held with the Superusers to share information about trends, algorithms and/or training issues that arise at the local level. Phone coaching and technical assistance is available to the Superusers from the DCBHS Training & Technical Assistance Program at UBHC-BRTI.

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## Findings

### Identified Strengths in IMDS Training

- UBHC-BRTI Trainers have a thorough understanding of system of care principles and because they also provide the core system of care training (e.g., wraparound, child and family teams) they are able to inform IMDS training with an understanding of how the assessment process is ideally supposed to work in a system of care context.
- UBHC-BRTI training managers are actively engaged in professional collaboration and inquiry with CANS experts and users, nationally.
- UBHC-BRTI provides on-site technical assistance, on-line and telephone consultation. UBHC-BRTI trainers describe a high degree of flexibility and a willingness to adapt training content, schedules, and location as needed. Survey results, however indicate that many users do not know about this or have had difficulty accessing it.
- The Superuser concept is promising, where available. According to respondents, having supervisory staff that can support the use of these tools is critical. Meetings of Superusers also afford an opportunity for regular, system-wide feedback.
- UBHC-BRTI has modified training in an effort to better serve users in DYFS and JJC. This includes the development of vignettes that reflect the types of needs and issues that are common to the children and families served by each system.
- The availability of both in-person and CD training resources increases training options and allows workers to receive training as needed. The on-line certification process is an added convenience for providers.

### Identified Challenges in IMDS Training

- Some of the problems with the assessment process appear to be related to insufficient system of care core knowledge, particularly by users in DYFS and JJC (but among mental health providers as well). Staff in JJC and DYFS agencies are invited but not required to attend core trainings.
- DYFS and Juvenile Justice have trouble qualifying enough staff to complete the assessments. These staff either fail to achieve the required inter-rater reliability scores despite repeated attempts, are certified but don't do enough assessments to feel comfortable in their use, or leave their positions.
- Many still view the assessments simply as CSA-required paperwork and not as a tool for gathering information to guide the development of a treatment plan and monitor progress. This would suggest that follow-up training needs to be provided to support the full use of the tools.
- High rates of staff turnover (particularly in DYFS) confound training efforts and compromise the development of system wisdom. It is reported that certain DYFS offices have few people qualified to do an assessment. This may deter workers from making referrals for mental health services and it compromises the power of this process to broaden the thinking of all front-line staff.

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- It is reported that many new DYFS workers do not recognize behavioral health care needs, so they do not consider making referrals. This is an issue for supervision, but it may also represent a gap in training.
  - Providers expressed concern about the infrequency of Crisis Assessment Tool trainings and asked for additional advanced training to refine their administration and application of the assessment tools.
  - There is currently no recertification process, or any routine approach to maintaining inter-rater reliability. UBHC-BRTI recommended a two-year recertification process, but DCBHS has not yet approved this.

## Recommendations

For a State that historically has conducted virtually no routine data collection, a lot has been asked — and accomplished — in a short period of time. As one survey respondent said “At least we have a [data] system even with its problems.” New Jersey is *ahead of the curve* with a framework in place that will support movement toward a more equitable, data-informed system of care.

New Jersey is at a critical juncture in implementation; it is essential that steps be taken to bolster confidence in the assessment tools and process. New Jersey has sufficient experience with the assessment process to begin to consider mid-course corrections and modifications. Decisive and competent action is required, however, to increase stakeholders’ conceptual understanding of the process, respond to legitimate concerns of users, and restore confidence in the capacity of these tools to inform immediate practice decisions and guide the evolution of the system. This should be undertaken with extreme care, a high level of stakeholder involvement, a clear sense of purpose, and expert consultation.

It will be helpful for New Jersey to reach out to other states and learn about their efforts to institute an effective assessment and outcomes management processes. The Health Care Reform Tracking Project’s Report on *Promising Approaches in Clinical Decision-Making* (Pires and Grimes, 2006) includes a compilation of states’ general recommendations for effective use of standardized clinical protocols or guidelines. Modified somewhat, these serve as a framework for summarizing key recommendations to re-focus, refine and fully implement the IMDS process in New Jersey.<sup>5</sup>

- 1) Select protocols that are meaningful to stakeholders, including clinicians, local management entities, provider agencies and families, and make protocols transparent to these stakeholders.
  - The IMDS Tools are a good match for their intended purposes. The Independent Assessment did not identify a compelling rationale for switching to another

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<sup>5</sup> Health Care Reform Tracking Project Reports are available on-line as an Adobe Acrobat PDF. [http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising\\_approaches/index](http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising_approaches/index)  
<http://pubs.fmhi.usf.edu> click Online Publications (By Subject)

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assessment instrument. The instruments most frequently mentioned as alternatives (CALOCUS/CASII and CAFAS), as well as the CANS-based IMDS tools, have strengths and weaknesses and each may be more or less appropriate for different objectives. The search for the perfect assessment instrument is a red herring, diverting attention from fundamental, unresolved issues that would prevent the optimal implementation of any instrument.

- DCBHS should establish an IMDS Implementation Task Force which will provide ongoing oversight to ensure optimal IMDS implementation. This group should be staffed and include high-level representatives from DCBHS, DYFS, JJ, Education, DDD, Health, UBHC-BRTI, the CSA, the Child Welfare Panel, family organizations, CMO, YCM, MRSS, residential, inpatient, and other community-based providers.
  - The IMDS Task Force should gather, prioritize and act on stakeholder concerns and address these concerns without compromising the value of using a standardized assessment and a rational decision-making approach. It may prove very helpful to involve outside experts in this process.
- 2) Keep open lines of communication with those using and affected by use of the protocols, i.e., families and youth, clinicians, provider agencies, and other child-serving systems, such as child welfare, education, and juvenile justice.
- An IMDS Task Force should insist on transparency and establish a comprehensive two-way communication plan. The Independent Assessment Team heard a tremendous amount of rumor and speculation. It was not uncommon for an interviewee to claim that the system was/was not working in stark terms without being able to point to any data to substantiate these claims (e.g., the system of care only serves middle class children; MRSS is highly effective at preventing hospitalization; some providers stop providing services to high need children when their resources run out). The system cannot move forward until decisions can be informed by objective data and not hearsay.
- 3) Select or develop and utilize protocols and guidelines within a values-based and systemic context. In other words, know what values, principles, and goals you are trying to promote in your system, and be clear that the protocols you have chosen or developed will support these values and goals.
- This IMDS Implementation Task Force should work with stakeholders to clarify and re-build consensus regarding system of care goals and the specific ways in which the IMDS system will be used to support and evaluate progress toward those goals. Very important issues relating to local governance, target population, the CSA role, and allocation of limited system resources (among others) were raised during this Independent Assessment. As those issues are debated over the next few months, attend to alignment with the IMDS process and assessment protocols.
  - A critical next-step is the design of data dashboards, routine provider reports, and targeted inquiries – using the data that have been collected to support movement toward specified, desired outcomes (for children, programs and at a systems level).

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- Articulate core system-goals – these should be limited in number, clear, and accessible to a broad audience. The process of arriving at these goals will require stakeholders to focus their priorities. Typically, communities focus on the system’s ability to keep children at home (reduction in inpatient and residential care events and number of days in care), in school (primarily attendance, but also performance), and out of trouble (e.g., reduced delinquency). Wraparound Milwaukee and the Dawn Project in Indiana are good exemplars of how to use data in this manner.
  - Public relations and sustainability should not be overlooked when tending the system of care. Milwaukee stakeholders, for example, felt that having a protocol to capture and compare outcomes information was very valuable in terms of program sustainability. Milwaukee reported that ‘non-traditional strategies, such as the wraparound approach, gain credibility when the evidence of a reduced level of need is presented to external stakeholders.’
  - There are many examples of how data have been used to support the goals articulated for a system of care (Pires and Grimes, 2006). The Hawaii example below illustrates how a state management information system ensures that data analysis and program development go hand-in-hand.
  - In Michigan, analysis of the CAFAS data has enabled evaluators and the State to identify predictors of poorer outcomes with customary care; these predictors include: pervasiveness of problems across settings (e.g., home, school); impaired care giving environment; previous hospitalization for substance abuse or psychiatric disorder; and, placement out-of-home. Again, the State and its evaluator are using these data to promote targeted interventions that show evidence of efficacy when these predictors are in place. Their efforts to bring knowledge to the localities about effective interventions for various subgroups of children with whom the local community are struggling also creates incentives for the locality to use the CAFAS system.
  - In Hawaii, the greater evidence base underlying decision-making has been supported by highly structured accountability throughout the system. This comprehensive accountability has led to a resulting increase in available data for analysis...Utilization of out-of-state placements has dropped significantly from 80 youth to less than 10. Despite these gains, the state remains concerned about the numbers of youth for whom out-of-home treatment, particularly at the community-based residential level of care, is recommended by treatment teams. The greater level of information now captured regarding these youth, as well as the greater availability of community based interventions, will help in the pursuit of ongoing improvements aimed at minimizing the need for residential care.
- 4) Provide adequate staffing and resources at a state or management entity level to implement a protocol-based system. Create an adequate infrastructure for training, re-training and coaching in the use of the protocols.



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## Developing Capacity and Support at the State Level

- Responsibility for the IMDS process is divided between UBHC-BRTI, DCBHS, and the CSA (at the state level) and providers and partners who conduct and use the assessments at the local level. These parties communicate with one another in an ad hoc manner and often at cross purposes (e.g., training is developed, but then not approved; separate training schedules; little knowledge of each others' training). A management team (responsible to the IMDS Task Force) needs to be created (preferably with representatives from DYFS and JJ as well) to implement changes in a coordinated and timely manner.
- Identify or hire staff experienced in the development and use of outcomes management tools and processes for quality assurance and systems change. Consider creating an intensive professional development program and/or partnering with a university to build this capacity. Adequate support is needed to collect, analyze and utilize data.
- The New York State Office of Mental Health's Division of Children and Families is using CANS. New York State has rolled out its requirement that providers use CANS and in the process the state has sought out opportunities to introduce providers to the instrument and 'showcase' how various providers and counties are utilizing the instruments. At the local level, CANS is used in the context of the Single Point of Accountability (SPOA) where local committees monitor children's access to and receipt of more intensive levels of care. Each local SPOA functions somewhat differently, including the manner in which they use CANS. There is sufficient flexibility in this arrangement for the system to be statewide with room for local adaptation.

## Developing Capacity at the Local Level

- Develop a technical assistance plan specifically to help local systems of care managers and provider organizations re-think how they use assessments and outcomes data. This will be critical as a greater investment is made in evidenced-based practice.
- Create regional and statewide 'learning collaborative' opportunities and one-day conferences for providers and state and local administrators to present and seek input on their findings and strategies. Promote the replication of effective practices found throughout New Jersey.

## System of Care and IMDS Training

- Restore and expand (after a thorough review by all system partners and providers) a comprehensive agenda of System of care training, including training on the assessment process and tools. Review adequacy of training frequency and capacity to ensure that new employees can receive training within one month of hiring. Conduct a full evaluation of training content (including audits of training sessions), using experts from other states and system of care sites.



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- Require system of care training and IMDS training as contract deliverables. IMDS training will not ‘take’ if users do not have a thorough grounding in system of care principles and practices. IMDS training should not only focus on assessment certification, but on the use of the assessments for individualized treatment planning and supervision within a system of care.
  - Include more resources for mentoring, coaching and hands-on technical assistance. Invest in local system network training approaches to build cohesion and shared understanding at the local level.
  - Expand assessment training to school psychologists, social workers and guidance counselors as one aspect of engaging the education system and expanding access to the system of care.
  - Identify resources to begin to develop and use practitioner trainers from New Jersey. These would be individuals who understand the assessment process, have experience as trainers, and who are currently (or recently) users of the system within their own agencies. These trainers would have a lot of ‘street credibility’ and problem-solving sensibility based on their experience.
  - Work with the university system that graduates BA and MSW workers for New Jersey to infuse system of care and outcomes management concepts into higher education programs.

## Training for System Partners

- Expand the number, location and role of Superusers with particular attention to DYFS and JJC.
  - Consider creative strategies for assuring sufficient, integrated assessment capacity within DYFS and JJC. The ultimate goal is for front-line workers to conduct these assessments, but interim approaches should be developed that do not rely so heavily on community assessors. This might include identifying assessment liaisons in each office that have a reduced caseload to enable them to function as Superusers, conduct/help conduct assessments, and facilitate improved integration of DYFS and behavioral health – not removing this responsibility from workers, but supporting their growth in this area.
- 5) Integrate use of the protocols into everyday documentation requirements and everyday practice, rather than implementing them as an *add-on*. Make the tools a part of the culture of the system.
- Providers are responding to multiple requirements and needs vis-à-vis assessment, data collection and reporting. A complete review of these requirements and needs (across all systems and for each provider agency) should be conducted with the goal of reducing unnecessary duplication and increasing alignment with system-wide goals.

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- Within limits, the tools can be modified if there are specific concerns. In Oneida County, New York, providers worked with Dr. Lyons to adapt New Jersey's Strength and Needs Assessment to better suit their needs. (M. Fazio and A. Campell, personal communication, May, 2006)
  - Providers need opportunities to work together with family members and family organizations to develop effective strategies for working with families throughout the assessment process. This is one area in which the assessment process feels 'uncomfortable' to some – and they are not sure how to make the process less burdensome for families. Lyons and colleagues have developed family interview questions to help workers engage families in conversation about the topics addressed in the assessment. (J. Lyons, personal communication, June 2006).
  - Dr. Suzanne Button of the Astor Home for Children in New York is working closely with staff in her agency to develop the skills and techniques for using data to inform practice and monitor outcomes at the child and program level. As a part of her work, she has developed a CANS process evaluation designed to assess the implementation status/issues related to its use. This brief, Likert-scale assessment can provide supervisors with insights regarding opportunities to more seamlessly embed this instrument in everyday practice. (S. Button, personal communication, June 2006).
- 6) Establish quality control in the use of protocols, which requires attention to data collection and analysis at both the service and systems level, and attention to use of the data to inform quality efforts.
- The CSA's application of decision-support protocols must be transparent. With appropriate assessment and decision-making fidelity measures in place, the locus of monitoring the accuracy of assessments can shift away from the authorization process.

New Jersey should examine the choices other states have made about how to use assessments and clinical guidelines in relationship to gatekeeping. The goal of these processes is to maintain the focus on providing the most appropriate services to children in an equitable manner in keeping with system of care principles. This is best accomplished through a combination of skillful and creative planning, team decision making, clinical expertise, objective and uniform assessment linked with data-based decision making (supported by algorithms and EBT guidelines). Checks and balances in the forms of retrospective case review, auditing, and data analysis help keep the system on track and accountable.

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Apart from a thorough quality assurance approach, concerns about inaccurate assessments have been handled in different ways. Philadelphia set up an independent assessment entity. Michigan conducts parallel assessments done by both providers and independent university-based evaluators. Some use a group process for completing assessments. In any case, auditing processes and regular analyses of aggregate data will help flag concerns. New Jersey does not have any of these processes in place at this time.

- Recertification in the use of IMDS tools should be required to assure continued high levels of inter-rater reliability. The state of Hawaii currently requires annual recertification in the use of clinical tools (not CANS) and New York is developing a recertification process as well.
- 7) Do not use data related to use of clinical protocols to “beat up” on providers; use data to improve quality, including providing technical assistance, consultation and coaching to providers and clinicians.
- Use the data. Routine, constructive reports will help dispel concerns about the validity and practical utility of the data.
  - Requirements for submitting accurate, complete, timely data should be very clear and specified in providers’ contracts. Phase in compliance requirements and provide technical assistance to help providers be successful. As standard business practice, sanctions for non-compliance should be spelled out as well. This assumes providers have been a part of the conversation, that their concerns have been addressed, and that the system for electronic/fax data submission smoothly.
  - The provider community should be prepared for change and the state should support *retooling*. It is very likely that the data will reveal some trends and practices that are inconsistent with the values and mission and/or are found to be ineffective.
  - While rebuilding trust and re-focusing this effort, New Jersey would be wise to stay away from any punitive action directly tied to the data. In Michigan, for example, the Level of Functioning project provides monthly feedback to the participating community mental health centers regarding youth who are making poor progress in treatment. Additional reports are used to ensure record compliance, monitor at-risk youth, and assist in reviewing the adequacy of treatment plans. The project also generates outcome data for children with different types of presenting issues. The mental health centers were not required to participate in this project, but now over half do, in part due to the helpful data feedback they are receiving.
- 8) The use of standardized instruments works best for children and families when it is embedded into a system that is strengths-based, family-driven, and committed to the principle of individualized care. Clinicians that embrace and are skilled in this practice model tend to make the most appropriate use of standardized instruments to help guide service planning and care provision.

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- As discussed previously, commitment to system of care values and an understanding (by all partners) of system of care practices are prerequisites to the IMDS process being fully implemented. Clear articulation of commitment and goals by leadership is critical.
  - Look closely at the relationship between the assessments, treatment planning, and supervision. Review treatment plan formats to determine how they can be made more consistent with the values and practice model. Aligning the treatment plan with the assessment will make it more likely that the data will be used for planning. The Bronx Single Point of Accountability and the New York State Office of Mental Health's New York City Regional Office have developed a treatment plans that parallel the CANS and has found it to be helpful (M. Zivian, personal communication, June 2006).
  - Respondents expressed some concerns about the IMDS assessments and decision-making process in relationship to children described as having 'specialized treatment needs' (e.g., trauma, sexual abuse, fire setting, sexually aggressive). Be as specific as possible about the nature of the concerns and whether those concerns relate to the assessment, access process, or availability of appropriate treatment. Review the use of supplemental IMDS modules and other non-IMDS assessments to determine what is helpful and what needs to be supplemented. This would be an excellent issue for discussion among CANS users in other states – Are these tools reliable? What other diagnostic instruments are used for specific concerns? Which instruments are most consistent with and helpful in this paradigm?
  - Reach consensus about how the assessment and enrollment process will both respect the integrity of the Child and Family Team process (and other forms of local decision-making) and utilize objective data-based decision making and data analysis to inform service delivery and system design.

In a true Wraparound model, the locus of decision-making is with the Child and Family Team (which is accountable in some way for the decisions it makes — and possibly fiscally accountable). There may be local or regional entities which work with the child's family and providers to review information and make a determination about the use of more intensive services. Algorithms and standard assessments may play a role in determining eligibility, but not used rigidly for level of care determination. There are many variations that New Jersey could consider to assure that plans are individualized while preserving the best aspects of the IMDS process. ■

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# Chapter 4: Care Management

## Research Question:

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- **Does the care and case management system promote good care and case management practices, such as continuity of care, and is the system reflective of national best practices in case management models?**
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## Introduction

Care and case management efforts are central to New Jersey's system for providing timely, accessible, effective mental health services to children and their families. However, these services can be assessed only in the context of the total service system as designed and as currently being implemented. Therefore, the following review of the care management (CMO) and case management systems (YCM) is provided in the context of a review of the service array and interaction among system partners (CMO, YCM, MRSS, FSO, CSA, Providers) that are developing in the Children's Behavioral Health System. This section of the Independent Assessment:

- Provides a brief overview and resources related to the evidence base for case management and national best practices in case management
- Briefly describes the conceptualization and implementation of the care and case management system in New Jersey
- Reviews New Jersey's care and case management in the context of the new service system for children's behavioral health services, in relation to best practices and in the context of implementation timelines. Strengths, challenges and recommendations are provided for the system as a whole and, as appropriate, at various levels including:
  - **Practice level** — Within a given service (e.g., CMO, YCM)
  - **County level** — Interactions among service components and among county structures
  - **State level** — Interactions among local and state policies, procedures, and practices

## Background

Case management best practices presented in this Independent Assessment are based on two sources (1) a literature review of effective case management practices and national best practice sites designed to service youth and children with serious emotional disturbance and their families (Friedman, 2006) and (2) a recent article reviewing the impact of cost plans on service authorization and utilization (MacIntyre II, Essock, Clay, Zuber, Felton, 2006). The literature review was combined with the identification of best practice sites nationally

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that adhered to common elements of effective case management practices. The review of the research literature notes that, “the model for which there seems to be the greatest research support for children with serious mental health challenges and their families is the wraparound model, based on system of care values and principles” and that “This model, or models like it that have measures that allow for the assessment of fidelity to the model and have demonstrated that fidelity is associated with better outcomes for children and families, may be particularly useful for developing effective case management practice” (Friedman, 2006, p. 68).

Two recent reviews of the research on effectiveness of case management arrive at the following conclusions. The 1999 review by Burns, Hoagwood, & Mrazek examined five randomized trials of case management and a number of quasi-experimental and uncontrolled studies. The conclusion reached in this review is that there is a small evidence base indicating that case management may be effective for children and youth with serious emotional disturbances. A second and more recent review (Farmer, Dorsey & Mustillo, 2004) examined many of the same studies as the Burns et al. review but additionally examined four randomized clinical trials of case management and a quasi-experimental study of case management effectiveness. They concluded that this “respectable evidence base” provides support for the efficacy of case management for children and youth experiencing mental health problems. In addition, Farmer et al. reviewed studies of the Wraparound care coordination concluding that utilizing the process “shows positives gains” for children. However, they also indicated that fidelity measures and more rigorous methodology are needed to produce more definitive outcomes.

Friedman (2006) reviewed nine case management practices with a focus on the specifics of what has been implemented in order for children, youth, and their families to be supported effectively. Key characteristics from these case management exemplars fell into the broad categories of:

- Family engagement and shared decision-making
- Family focused services
- System feedback and outcome management

These characteristics were seen as indicators of processes that result in effective supports for children and families based on the literature related to predictors of family satisfaction with public mental health services, the characteristics of well-functioning mental health programs and systems, and the design of case management systems. Brief highlights of the findings related to these three areas are provided below and the complete report (Friedman, 2006) can be accessed through the Louis de la Parte Florida Mental Health Institute.

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## Family Engagement and Shared Decision-Making

Exemplary case management programs facilitate engagement of families and promote shared decision-making by:

- Orienting families to roles and services
- Providing frequent contact and communication between case managers and families
- Putting structures in place to increase family voice in treatment team meetings
- Involving family members in system policy, service design, and evaluation activities

## Focus of Services on the Whole Family

Strategies related to focusing services on the whole family include:

- Creating individualized family service plans that provide services desired by and targeted to the family
- Monitoring family functioning over time
- Team-based exploration of family strengths and needs
- Utilization of professional and natural supports to achieve family and child outcomes
- Service duration based on need (Range of 12 to 20 months)
- Small caseload sizes. Caseloads greater than 1:15 were associated with poorer outcomes in one study (Daleiden & Tolman, 2005).
- An array of family-focused services including respite care
- Home and community based services targeted to functioning in the natural environments of children: the home, school and community and designed to promote the most appropriate, least restrictive environment for children, youth and families (e.g., in-home family therapy, in-home case aides, mentors, tutoring, flexible funds for nontraditional supports (e.g., child care, housekeeping).

Overall, the sum of the parts, including the implementation of system of care values and philosophy, may be more important than the presence or absence of any single element. In this sense, the case management models may be integrated and compensatory; to the extent that diverse aspects of case management can compensate to meet the needs of families, so that any single element is not, in and of itself, critical (see Fixsen, Naoom, Blase, Friedman & Wallace, 2005 for further information on the application of integrated and compensatory frameworks).

## System Feedback and Outcome Management

### Identification and Measurement of Core Outcomes

Best practice sites identified and measured core outcomes utilizing a number of standardized clinical and social functioning measures as well as system level measures. Typical standardized clinical and social functioning measures included the Child and



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Adolescent Functional Assessment Scale (CAFAS), the Child-Behavior Checklist (CBCL), the Behavior and Emotion Rating Scale (BERS) and the Child and Adolescent Needs and Strengths (CANS) measure. Given New Jersey's use of the CANS instrument, it is of interest that two of the systems indicated that they are moving from their current measures to the CANS because of the greater perceived utility of the CANS. System level measures also were assessed frequently including such measures as days in school, juvenile justice offenses, days in restrictive settings, costs per child, and services received. Such system level measures increase the likelihood of buy-in from all child serving systems and the development of a robust and functional system of care across departments and stakeholders.

## **Regular and Multi-level Feedback Loops for Process and Outcome Data**

All nine best practice sites utilized process and outcome data to improve services. Data are used to guide case manager development and support accountability at the case manager and supervisor levels. Data reviews are a feature of regularly scheduled weekly supervision and include outcome tracking and the use of real-time service data to monitor clinical functioning, expenditures, eligibility, and service utilization at the individual client and at caseload levels. In addition, at some sites monthly and quarterly reports also are made publicly available to all service providers and to the community at large. These community "report outs" create the opportunity for regular feedback from stakeholders as system strengths and areas for improvement are made public.

Measurement of fidelity to the case management practices occurred in several of the best practice sites. In particular, the Wraparound Fidelity Index (Bruns, Suter, Force & Burchard, 2005; Taub & Breault, 2006), which measures fidelity of the service planning process to the Wraparound process and values, was used in order to detect drift from practice. Fidelity measures when combined with outcome measures greatly assist continuous quality improvement efforts, and provide the data necessary to discriminate implementation problems from program effectiveness issues. Corrective actions and mid-course corrections are difficult to make when outcomes are low and fidelity is not being monitored. Should program improvement plans be focused on critiquing the adequacy of the intervention for meeting the needs of the population or should they be focused on improving adherence to the hallmarks of the service? In summary, timely clinical data, and cost and utilization information, together with fidelity measures, facilitate quality service delivery and case planning as well as assisting supervisors in knowing when and how to modify or bolster case management practices.

Outcome and cost analyses for the nine best practice sites indicate that children and youth who remain in treatment over time are likely to see substantial improvement in emotional and behavioral functioning (Friedman, 2006, Appendix R, p. 155) and that high fidelity, case managed, community-based services resulted in cost savings over restrictive care or care as usual. Recent data from Kids Oneida Project in New York (MacIntyre II,

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Essock, Clay, Zuber & Felton, 2006, p. 590) provide an indication that continuity of care may be an important feature of a high quality, cost-effective system. Data from the project found that longer stays in service were associated with more changes in case managers ( $P < .001$ ).

## **Background and Current Status of Care and Case Management**

The *Children's Initiative Concept Paper* (State of New Jersey, 2000) articulated both the values and philosophy of a system of care and the structural components, financial resources, assessment, access and service array changes that would be employed to operationalize those values and principles. The paper called for the development of Care Management Organizations to provide intensive care management for children experiencing the most serious mental and behavioral health issues, an expanded array of services including expanded community-based, home-based, and crisis services, and the integration of existing community services into this new system design. The original design did not include a level of case management specifically for youth with moderate needs. Rather the intention was that such children and youth would be referred directly from the CSA to community agencies.

Any significant system change needs to evolve and develop as it moves from concept to reality. One significant change was the incorporation of an additional level of case management into the system design. This case management service for youth with moderate needs was formalized under the organizational structure of Youth Case Management services. In point of fact, such services had long been a part of many child serving agencies and due to the need and function they were 'formally' incorporated into the system design.

Thus, the New Jersey care and case management system design was predicated on getting the right level of service to the right child at the right time based on a timely, common, reliable, valid assessment process. The strength and needs assessment process and instruments (CANS), and role of the Value Options CSA are reviewed in other sections of this Independent Assessment. However, elements of policy and practice related to assessment, level of service assignment, and referral must be considered in any evaluation of case and care management best practices, current efforts, and impact on continuity of care.

New Jersey has chosen to implement a model of care and case management that emphasizes care manager and case manager as service broker, primarily assisting families in accessing, maintaining and adjusting services and de-emphasizes direct service provision (Evans and Armstrong, 2002). And in the case of the Care Management Organizations (CMO), the non-profit organization is prohibited from providing direct services. CMOs are designed to serve the needs of the most seriously emotionally disturbed children and function as a community-based alternative to more restrictive out-of-home services (e.g., residential treatment centers). However, caseloads are mixed with services provided to children with serious emotional disturbance in the community, and to children in residential placement, either at the time of referral or with service continuation for children who are placed in such

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settings while receiving CMO services. To enable care managers to provide intensive care management, caseloads are capped at a ratio of 1 care manager to 10 children. CMOs were initiated with capacity caps during start-up but were expected to expand the number of children and families that could be served once the CMO was fully operational.

The provision of Youth Case Management Services (YCM) predates the implementation of the children's behavioral health care system and these services are operated under the auspices of a variety of human service agencies with diverse mandates. While YCM case managers do not provide direct service in their role, they are embedded in service agencies. These agencies do provide services to some of the children and families receiving YCM case management services. As the children's initiative evolved, the need for YCM services within the system of care became apparent and they were incorporated into the overall system design.

Youth Case Management services are intended to serve youth with more moderate needs identified either through the Strengths and Needs Assessment at initial referral, and/or through the Joint Care Review process as they are stepped down from residential services or stepped down from CMO services, or are referred from Mobile Response Services (MRSS). However, the YCM case management services also retained their traditional service provision by responding directly to referrals from the Juvenile Justice Court system to provide case management for youth transitioning from hospital settings back to the community and for youth in the child welfare system. While YCM case management is critical to the children and their families, overriding systemic issues have made it very challenging for the service to function well (e.g., referral of youth and families with high level needs without access to the range of resources needed, sudden influx of cases, higher than recommended caseloads in some YCMs).

Mobile response units (MRSS) attend to children and youth in crisis with the goal of stabilizing the situation and preventing placement disruption with subsequent referrals to services as needed at point of discharge from MRSS. The MRSS component of the system has been implemented with many benefits realized. MRSS serves as a point of referral to care and case management, albeit through the CSA.

While Family Service Organizations are not part of the case and care management system per se, they provide significant support to families receiving services through the CMO through individualized family support, advocacy and system navigation and through family support groups. Family Service Organizations (FSO) also play a supportive role in care management by attending Child and Family Team meetings to support families receiving CMO services. Overall the FSO roles are more related to service provision and support to families (peer support, family support groups, advocacy and system navigation) than to care and case management.

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## Findings

The strengths of New Jersey's care management system are reviewed in light of the literature review, the summary of the characteristics of nine national best practice sites, and the above brief overview of the current New Jersey care/case management structure. Findings rely on results from focus groups held with FSOs, CMOs, MRSS, and YCM providers as well as focus groups with residential providers, members of the Judiciary, members of NJAMHA, and representatives of the County Mental Health Administrators along with individual and small group interviews utilized to clarify data, documents, policies and procedures. In addition, responses to the statewide web-based survey that included ratings and comments related to key care and case management issues (e.g., collaboration, appropriateness of service, knowledge of system of care principles and values).

### System Strengths

New Jersey has developed a very sound structure for the provision of children's behavioral health services and case and care management adopting many of the state-of-the-art structural recommendations related to systems of care (Pires, 2002). The structure has the potential to match level of care to level of needs as well as the ability to respond to crises, prevent placement disruption, and provide services to prevent the utilization of more restrictive services. The use of a common assessment instrument (CANS) together with CMO, YCM, MRSS, and FSO structures represents a strong state and county effort to develop a comprehensive systems approach to meeting the mental health needs of children, youth, and their families. This statewide approach and the county efforts are commendable and the gains achieved in the context of the political turmoil and service climate should be celebrated.

### Case Management Strengths

The Care Management Organization structure is particularly strong reflecting many best practices in case management with adherence to low caseload ratios (1:10), individualized care coordination and management, service duration based on need, flexible and relatively robust initial pre-authorization packages, and access to flexible funding. The 1:10 ratio makes it possible for care managers to deal with the complicated problems and issues presented by these children in the community while taking time to develop relationships, identify strengths and partner with parents and formal and informal community resources. Data sources related to structure include documents from the CSA regarding pre-authorization service packages, the web survey detailing case load sizes, and focus group comments.

In addition to a structure consonant with best practices, the CMOs also appear to generally function within the best practice range by operationalizing system of care values through Child and Family Teams, engaging families in shared decision-making, providing home and community services in the natural environments of children, promoting the most appropriate and least restrictive settings, and utilizing a range of services and supports through authorization and the use of flexible funding. There was some sentiment across

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stakeholder groups that the CMOs, overall, appear to be succeeding in meeting the needs of children and youth with the most serious mental health and behavioral issues. The “right” children are being referred to CMOs through the common assessment protocols and multiple stakeholders report and recognize the benefits of the individualized and intensive work done to serve these children in the context of their family, schools, and communities. Data related to pre-authorization service packages, the web survey and focus group themes from CMOs, members of the Judiciary, and some family interviews indicated that practices were generally beneficial. However, there were concerns raised about CMO service levels for youth in residential facilities, the ability of CMOs to access timely flexible funding through the authorization process and the degree to which informal supports are included in planning teams.

The CMO care managers and supervisors are better equipped with the knowledge needed to promote the values and principles detailed in the *New Jersey Children's Initiative Concept Paper* (State of New Jersey, 2000) as a result of receiving training in systems of care and in wraparound approaches. As noted in the best practice information above, models that have fidelity instruments are particularly useful for developing quality services. The CMOs have the opportunity to measure fidelity to the wraparound approach through the use of the Wraparound Fidelity Index (WFI). While the regular use of the WFI is not in place for all CMOs, it is available to help organizations assess implementation fidelity and, over time more extensive use of the WFI could be encouraged and supported by the CMO community of practice and through contracting requirements. When fidelity measures are combined with outcome measures, organizations have the opportunity to discriminate implementation problems (low fidelity) from effectiveness problems (unsatisfactory outcomes). This ability makes it much more likely that continuous quality improvement efforts will be targeted to the right variables and that program and practice improvement will occur. Without fidelity measures and an understanding of the core components of a service, organizations cannot discriminate implementation problems from service effectiveness issues and are severely hampered in both analyzing problems and in developing the appropriate solutions to improve quality.

Youth Case Management Services are a valued and important part of the system and represent a general improvement in the service system. As one participant noted, “...the in-community services part of what the Youth Case Management has been able to do has been a great help and a great improvement over what we’ve had in the past.” However, Youth Case Management services are unable to adhere to best practices due, in part, to large caseloads. Large caseloads combined with the lack of a consistent case management model, lack of access to the FSO services, and a more limited pre-authorization package and timeframes make it unlikely that the best practices related to family engagement and shared decision-making and a focus on the whole family can be achieved by the YCMs.

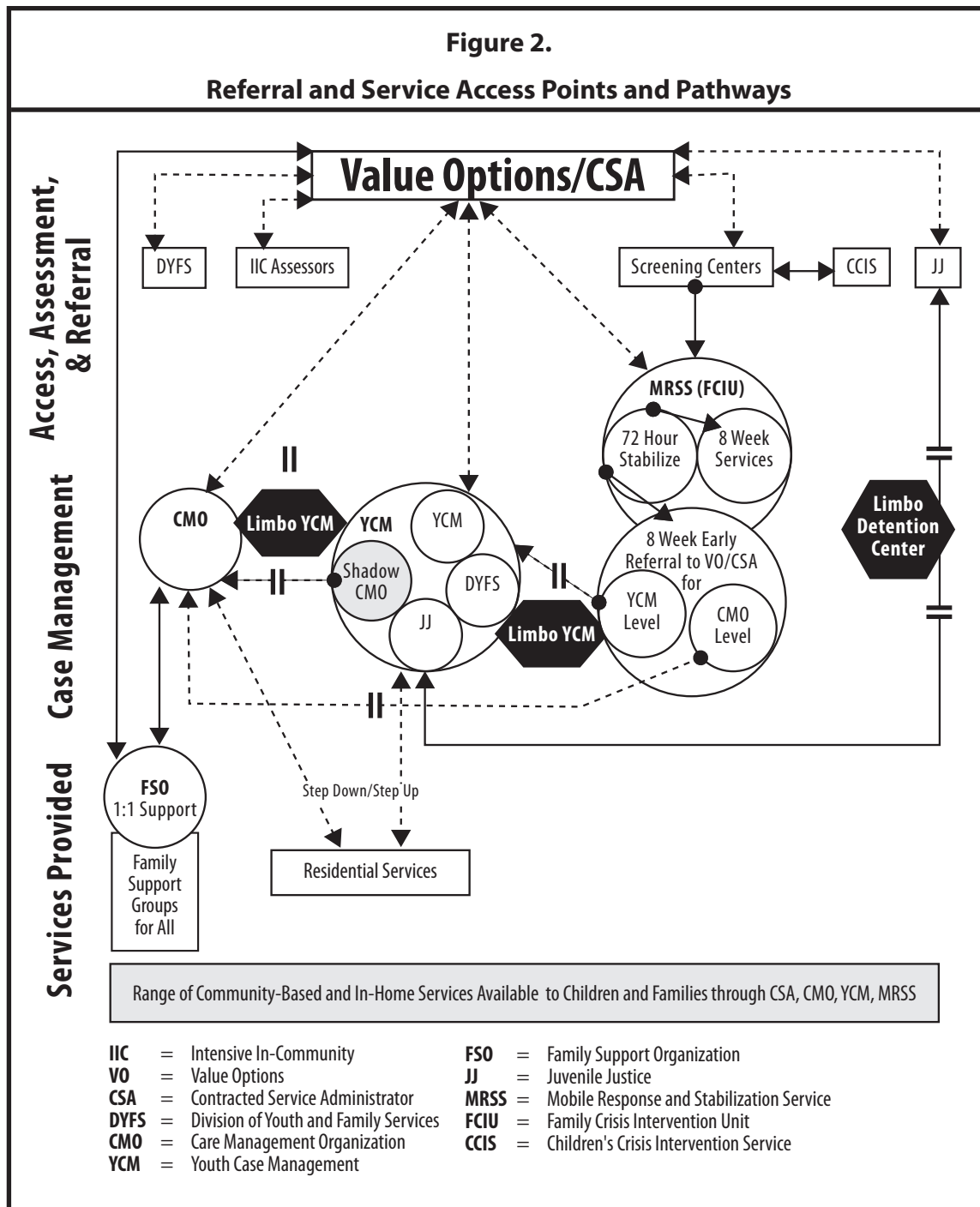
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## Needs and Challenges

The preceding brief description of the current system and its strengths provides only the broadest outline of the system and does not do justice to the complex realities of meeting the complicated needs of children and youth and their families while simultaneously creating, initiating, developing, transitioning, and making *course corrections* related to the bold service design in an often ever-changing political and social environment.

Some of the complexity and reality of the care and case management system is represented in **Figure2**. Referral and Service Access Points and Pathways. Figure 2 is not intended to be a comprehensive representation of all the interactions that take place in the Children's Behavioral Health System and in the lives of children, youth and their families as they access and receive services. Rather it is presented to highlight particular service flows and system interactions that relate to service capacity, continuity of care and integration with system of care values and principles, timely access to the appropriate levels of care, and effective transitions (step up or step down in service intensity). The dashed lines represent pathways that require looping back through the assessment and authorization process by the CSA. Solid lines represent direct access in terms of communication and/or direct referral. Breaks in dashed or solid lines represent the challenge in making that transition smoothly or in accessing a service at all. (Data from document reviews, multiple focus groups, individual interviews, data from the CSA and from an extensive web-based survey were utilized in creating this depiction. The Independent Assessment Team is grateful for the time that so many individuals devoted to helping us acquire the information and an understanding of the system. Given the complexity, all errors in depiction are those of the Independent Assessment team and amenable to correction).





Overall, **Figure 2** is designed to illustrate the following interrelated challenges and their impact on care and case management and in the overall design of the service system as it is currently being implemented and experienced by children, youth and their families:

- Service capacity issues
- Access to appropriate service intensity and array



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- Transition challenges and service continuity
  - Continuity of care and integration with system of care values and principles

## Service Capacity Issues

In many ways, service capacity is at the heart of many of the challenges facing the care and case management system. The system is presently unable to operate as designed due to the following interrelated capacity issues. In a positive vein, CMO caseloads are capped at a ratio of 1:10 and, as noted previously, this is real strength of the design and in the implementation of the system. However, the intended expansion of slots in the Care Management Organizations did not occur as planned in many counties, imposing serious capacity constraints. These constraints result in children with more serious needs receiving less intensive services based strictly on CMO capacity issues. Both data from Value Options and comments across focus groups, web survey participants and from individual interviews validate this concern and highlight the impact on service provision. Focus group members, individual interviewees, and web survey participants all commented on the lack of full implementation of the CMO service segment. Stakeholders commented that: "...Youth Case Managers are getting much more serious cases than they were ever intended to get because CMOs have been capped at a certain number. And I would suggest artificially. And, I'd also suggest, having been part of the discussion from its inception, that that was never intended. This capping of services was only intended to give this an opportunity to get off the ground." (Judiciary focus group) And "Within the first year of operations we were reduced from 240 to 180 and we have been there for five years..." And, "We were supposed to go to 180 for year two and we were capped at 120 and this caused a shudder through the YCMs..." (CMO focus group).

The children and youth who need intensive care management services but are being referred to YCM are depicted in Figure 2 as the "Shadow CMO" caseload in YCM. Data from Value Options on the number of youth who require CMO services but who are referred to YCM illustrate quantitatively the capacity issue. For example, CSA data from Table 10 for January through April of 2006 indicate that 22% (90) of the children meeting criteria for CMO services were referred to YCM due to CMO being at capacity (See Figure 2: Shadow CMO). This total number (90) is nearly double the total number of appropriate referrals to YCM (53) through the CSA Selection Referral process for that period. Lack of capacity in CMO services resulted in either placements in YCM services or delays in services as youth were "held" for referral re-presentation the following week. (See Figure 2: MRSS 8 Week Early Referral for CMO Level). In summary, both the qualitative data from focus groups, individual interviews, and the web survey as well as the quantitative data indicate that capacity issues are resulting in inappropriate referrals and delays in care management provision at the appropriate level.

<b>Table 10.</b> <b>CMO/YCM CSA Selection Referrals</b> <b>for the Year-to-Date 2006 (January–April)</b>				
<b>County</b>	<b>Referred to CMO</b>	<b>Referred to YCM &amp; Met YCM Criteria</b>	<b>Referred for Services by CSA</b>	<b>Met CMO Criterion but referred to YCM because of no openings</b>
Cape/Atlantic	27	2	1	8
Burlington	20	4	0	5
Mercer	25	7	0	14
Monmouth	18	16	0	12
Union	30	7	1	2
Middlesex	23	2	7	15
Bergen	27	2	0	6
Hudson	22	5	4	3
Camden	21	6	7	16
Passaic	13	0	1	0
Essex East	45	0	2	4
Essex West	51	2	2	5
<b>Totals</b>	<b>322</b>	<b>53</b>	<b>25</b>	<b>90</b>

A brief comparison of the established pre-authorization periods and the basic pre-authorized package of services in **Table 10** make it clear that children and youth referred to YCM, while qualifying for a more intensive level of service will not receive the same level of service as youth referred to the CMO. These “Shadow CMO” youth cannot receive the necessary time and attention from Youth Case Managers who have higher caseloads (e.g., 1:22), who are not trained consistently in, nor expected to implement wraparound approaches, and who do not have access to the same level of pre-authorized services as CMOs. For example, the pre-authorization package comparison in the table below illustrates that CMO outpatient resources can be provided for up to 30 visits in one month while YCM preauthorization is the equivalent of 7 visits for one month. Thus, children who need CMO services but are referred to YCM are pre-authorized to receive only 25% of the outpatient services available to their counterparts who gain access to the CMO level of care. This pattern is consistently evident in the side-by-side comparison of both established authorization periods and the pre-authorization packages in **Table 11**. Thus, level and intensity of service are not tied to youth need but to the service setting due to capacity issues.

<b>Table 11.</b> <b>Comparison of CMO and YCM Authorization Periods</b> <b>and Pre-Authorization Packages</b>		
<b>Type of Service Available</b>	<b>CMO</b>	<b>YCM</b>
<b>Established Authorization Periods</b>		
<b>Initial Authorization Period</b>	Up to 90 days	Up to 90 days
<b>Subsequent Authorization</b>	Up to 90 days	Up to 30 days
<b>Authorization Thereafter</b>	If ISP submitted w/no service request for either Medicaid or Non-Medicaid services, only CMO authorization for 30 days	Up to 30 day increments per child's needs
<b>Expected LOS</b>	12 to 18 months	3 to 4 months
<b>Pre-Authorization Package</b>		
<b>Outpatient</b>	Up to 30 visits for one month	up to 20 visits for 90 days (roughly 7 visits per month)
<b>Intensive In Home (IIC)</b>	Up to 12 hours for 90 days —Licensed Clinician Up to 21 hours for 90 days —Master's or Bachelor's level under supervision	Up to 6 hours for 90 days —Licensed Clinician Up to 15 hours for 90 days —Master's or Bachelor's level under supervision
<b>Behavioral Asst (BA)</b>	Up to 60 hours for 90 days	Up to 35 hours for 90 days
<b>Medication Eval/Mngmt</b>	Not referenced (Why?)	5 visits for 90 days
<b>Out of Home Treatment</b>	Up to 30 days	No pre-authorization

Generally, YCM services are oversubscribed with current caseload capacity ranging from 103% to 150% in 14 counties and from 70 to 95% in six counties (DCBHS Agency Summary, Report No. NJ0232.1, September 05, 2006). While the rising YCM caseloads initially stemmed from the 2004 requirements in the child welfare lawsuit to assign all children in residential care to case management services, it should be noted that service capacity was much lower at that time. The December 1, 2004 DCBHS Agency Summary indicates that on average YCM services were at 53% capacity with 19 of 21 counties with capacities ranging from 22% to 79%. Only Burlington and Mercer were above capacity with both operating at 129% of capacity. However, the sudden increase in a two-week period quickly brought average capacity to 92% with six counties above 100%, ranging from 102% to 205%. Whether due to lack of planning, problematic communication, or urgency related to the enforceables related

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to the child welfare lawsuit, the caseload of YCM staff jumped dramatically in a two-week period. In addition, it was not clear that all these youth had serious mental health needs.

Comments from focus group participants indicated that YCM responded as well as possible but that the sudden influx was quite stressful, despite the “slack” in the system. In addition, YCM continues to be under pressure from the juvenile justice courts to meet service demands for juveniles in detention centers and shelters. Combining this influx of previous DYFS cases and Juvenile Justice referrals, with the appropriate YCM referrals received through the CSA, from MRSS, and from CMO step-down plans and the inappropriate referrals for youth who need CMO services results in a “perfect storm” of service oversubscription (See **Figure 2** – YCM circle).

This service oversubscription also impacts service continuity, especially at points of transition when children, youth and their families are particularly vulnerable. Rocky transitions can contribute to re-escalation of problems in response to the delay and uncertainty about future services and supports and due to the discontinuity in relationships (e.g., shift from care to case managers). CMO, MRSS, and members of the Judiciary focus groups all noted significant delays in service provision and contact with the family following a referral to YCM. The Judiciary was particularly concerned about youth languishing in detention while awaiting YCM services. Residential providers also noted that when YCM case managers are assigned to work with youth, the case managers frequently call asking for information and direction from the facility about what needs to be done and what is known about the youth. Some of these delays also were noted by the YCM focus groups members who additionally cited lack of timely and accurate notification of referrals and lack of information from the CSA as another significant factor. As one respondent noted with regard to communication with the CSA, “...Then we get yelled at though if we don’t pick up a kid within our timeframes and we have had multiple meetings, where we will say, ‘you open Absolute, you look at your caseload and magically, there is a new case there... I immediately go look and then I will see there has been this long conversation between the CSA and the parents and the providers and they all concluded that YCM would be the best place for this child, which is great, but why didn’t somebody tell us.”

Many stakeholders in the CMO, YCM, and MRSS focus groups recognized that the YCM services in all likelihood were doing all that they could but that in some counties volume (e.g., caseloads higher than 1:22) and inappropriate referrals (e.g., Shadow CMO youth) were creating problems in terms of timely service. A number of stakeholders expressed concern that YCM is asked to fill all gaps without adequate resources. Others were concerned that YCM is evolving quickly into the next flashpoint, just as DYFS caseloads were for the child welfare reform. Focus group participants noted that the YCMs really struggled because “based on the Child Welfare Reform Plan giving 300 kids [to YCM services] in 24 hours to meet a marker for the Child Welfare Reform Plan, the court’s enforceable...it’s getting to the point where it seems to be evident that the Youth Case Managers are starting to suffer from the same problems DYFS workers did when DYFS had all those cases.”

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Another theme of multiple focus groups (MRSS, FSO, and CMO) was the current organizational arrangement for YCM services. The location of YCM within a larger host provider agency could lead to conflicts of interest (such as referring youth for services offered by the larger organization when those services may not be needed by a youth) and/or the lack of buy-in to system of care principles. As part of larger organizations, YCM directors and case managers attend to the values, mission, and practices of the provider agency, which may or may not be consistent with system of care values and principles. Focus group participants viewed this organizational arrangement as a potential barrier for YCMs to be fully committed to a system of care approach.

Transition issues (e.g., step up and step down in service intensity) and accountability during the transition also were reported to be problematic across stakeholder groups. Issues ranged from the reportedly excessive paperwork for authorizations and 30-day re-authorizations, to delays in both accessing information needed for submission to the CSA, to having transition plans processed in a timely manner by the CSA, to delays in getting services in place in the new setting. As one CMO stakeholder indicated, “One of the glitches that we have here is that when this (the transition plan) is forwarded to Value Options for approval, there is sometimes a time lag where it becomes unclear to whom the child and family belong. It has happened enough that I have dubbed these children ‘in the land of in between’ and what we do for children ‘in the land of in between’ is these kids are technically no longer at the CMO and yet, they are also technically not authorized as transitioned out and discharged by Value Options, so separate from the therapeutic implications, the risk management implications of that are somewhat stupendous.” Similar concerns were echoed by other stakeholders including the Law Guardians and Defense Attorneys: “From referral to implementation takes too long. Children linger in inappropriate facilities or go into crisis mode waiting for care. There are too few smooth transitions.” In summary, capacity issues combined with processing delays have had a reverberating impact on almost every part of the service system with children, youth and their families experiencing inappropriate levels of service, service delays, and lack of timely and fully informed transitions between levels of care.

Fortunately, there is a strong commitment in New Jersey to ensuring service provision and continuity for vulnerable children, youth and their families. This commitment comes through in the informal strategies and operating procedures that have evolved in order to ameliorate the impact on children, youth and their families. A review of each of these “informal strategies” provides further information about the validity of the concerns as well as highlighting areas that need to be addressed more systemically through funding, service integration, policies and procedures, communication, and accountability and feedback mechanisms.

One informal strategy identified by CMO staff involved keeping some families in the CMO system until they can discharge them to an *independent* set of circumstances in the community rather than even attempt any step-down to oversubscribed YCM services. In other instances, they informally *cover* for the service lapse experienced by families in transition. Second, MRSS services seem to be evolving into watered down case management services.

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That is, the MRSS team often stabilizes the placement early on and is ready transfer the child to a YCM or CMO service either after the 72-hour period or during the course of the up to 8 weeks allotted for services. However, this timely transition does not occur. Instead, due to known capacity problems the MRSS makes an early-on referral through the CSA for YCM or CMO, then keeps the family connected through the full 8 weeks that they are eligible for services, hoping to have the child gain access to YCM or CMO (See **Figure 1** – MRSS – 8 Week Early Referral to VO/CSA for YCM Level or CMO Level) or for a series of weekly re-presentations to the CSA Selection Referral process. MRSS, to some degree, functions as a *safety valve* for an oversubscribed system ensuring that at least some services are being received for 8 weeks and then hoping for access to the more appropriate level of care (YCM or CMO) through the CSA re-assessment and referral process. However, some MRSS Directors were very clear that their role is crisis intervention and stabilization and that providing treatment or functioning as a case manager for treatment for all youth for 8 weeks, is not their mandate and that they do not have the time or authority to monitor “treatment” delivery via Intensive In-Home Community and Behavior Assistance Services (IIC – BA) services. They also noted that even when “access” is gained to YCM services and the paper hand-off occurs that the YCM may not be able to get to that child or youth in a timely and functional manner (See Figure 2 – Limbo YCM from MRSS to YCM).

Thus, the MRSS “safety valve” helps maintain stabilization while awaiting openings and arranges for some treatment and intervention through (IIC-BA). However, it also means the MRSS compromises the function of crisis intervention and stabilization and in turn may experience a reduced capacity or a strain on service provision. In effect service delivery is not individualized but becomes standardized (e.g., 8 weeks of services) to compensate for transition and capacity problems. This situation may unnecessarily increase the costs associated with crisis intervention and stabilization and may lead to stresses in the MRSS system, which is currently very well regarded and seen as one of the best features of the system design.

Third, because there also are significant wait times to get the psychological and psychiatric evaluations requested by residential providers as admission requirements, judges reported that children in the juvenile justice system are being kept in detention rather than being sent home to await such evaluations. By staying in detention, county funds allocated to juvenile justice can be used to get timely evaluations needed to complete the documentation needed for service authorization. Youth also are awaiting actual connection with YCM and CMO services as well as residential placements while residing in detention and shelter settings (See **Figure 2 – Limbo Detention Center**). Overall, this informal strategy helps ensure more timely evaluations needed for referral and service authorizations and decreases the probability of re-escalation of problems at home while awaiting such evaluations. However, the strategy also requires a level of restrictiveness of setting (e.g., detention), however briefly, that would not be necessary if the services were more accessible in a timely manner.



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Fourth, children, youth and their families also benefit from care and case management that is family-focused. There are challenges to providing family-focused services that relate to:

- Funding authorization that is focused on the individual child
- The need to access services for adult members of the family so that children's behavioral and mental health needs can be addressed.
- Multiple care and case managers within the Children's Behavioral Health System and with other departments and entities (e.g., DYFS)

These three challenges frequently impact continuity of care and the quality of care and case management. With funding authorization focused on the individual child and with level of case management contingent upon the assessment process, it is possible for two children in the same family to find themselves in two different levels of care, one with a CMO Care Manager and one with a YCM Case Manager. And if there are also child welfare concerns then a DYFS case manager is added to the mix. The diverse plans, expectations, and resources can make for a well intentioned but confusing array of plans, meetings, expectations and resources for children and families. Some respondents noted that there are efforts made collaboratively by the CMO and YCM organizations to create one plan for the family by having the CMO also take responsibility for a child initially placed under Youth Case Management, when that child has a sibling served by the CMO. In addition, here are challenges for care and case managers when parental needs interact with the behavioral and mental health issues of the children, as they often do. In some cases, FSO staff play a key role for CMO referred youth in helping parents access necessary services (e.g., employment, insurance, medical care). For example, one FSO staff member commented that she was able to help a caregiver get money to pay insurance, have mental health testing and receive medications for herself. Except in isolated cases, such FSO *navigating* and support for families is not available to youth referred to YCM services.

The fifth significant issue is the coordination of case management services with other entities, particularly DYFS and the Courts. Both CMO and YCM care and case managers noted that there were collaboration, communication, and protocol problems that currently exist or that are just being addressed through "fix it" meetings at the county level. The following representative quotes illustrate the challenges in case coordination when other case managers are involved with different mandates.

- "DYFS has a very hard time letting go of some kids, even if there is no abuse, neglect, or permanency, sometimes they still won't want to close them. We have some difficulty with transferring the Medicaid...and they end up not having any insurance."
- "One of the problems with it also is that as they made the shift to YCM, they explained our job duties to us and educated us but they did not go out and educate DYFS, really the Juvenile Justice System and all that, so DYFS cannot understand why we can't place a kid in 48 hours, ...we have to go to the gatekeeper of Value Options, which is fine, but DYFS doesn't understand that, which seems to be that lack of education component, so we get a lot of very angry, hostile DYFS workers...."



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- “The court system still does not understand. We get 14-day plans that don’t have a return to court date. The latest one I got, they are telling us the kid is not going back to court, the Judge just basically said she does her time and she is done. But that the CMO should develop a plan, she is not a CMO kid.”
  - And as a counter point, “the jury was out on the judicial side, ...some of the biggest compliments we have gotten in (county) is judges....they say, I know if I order this kid to you, something is going to be done and now they have stopped doing that, but they still look at us favorably and I think they welcome us in the county..”
  - DYFS was asked to change more than any other part of the state bureaucracy, they were really asked to split their mission into a child protection mission and to hand off the behavioral health to a brand new organization that they didn’t know or trust....I think it is still a work in progress, especially as we share cases with DYFS...”
  - “...we just had a “fix it” meeting with our...DYFS local offices...It was a very helpful meeting but the big issue was opening and closing cases. When DYFS ends and we pick up, how long is there is a protection, or permanency issue they have to stay involved, should they come to child/family team meetings and...I think it is going to be better, but there was a lot of confusion.”

These representative quotes illustrate challenges related to the mutual education that needs to occur so that system partners (e.g., JJ, Courts, DYFS) understand the new functions and protocols and the reasons for these changes and the new system understands the concerns and challenges of these partners. There were hopeful comments and processes referenced from focus group participants indicating that linking protocols are being developed that detail who does what under particular conditions. Such linking protocols can improve system functioning and coordination of case management services. Areas that require such linking protocols include:

- Agreement about who is responsible for helping families decide upon and complete presumptive eligibility forms
- Access related to emergency placements
- Role of other case managers and requirements to attend/or not attend planning meetings
- Issues related to court ordering services that are basically voluntary in nature.

Finally, with respect to best practices in case management related to utilizing system feedback and engaging in outcome management, there are beginning strengths to build on. However, timely, useful process and outcome information at the local level is not yet in place so that case management system components can benefit from frequent, accurate feedback loops.

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In summary, there are service level strengths in the overall structure of the system, the use of a common assessment protocol, the adoption of values, philosophy, and principles of a system of care in some parts of the system and in the operationalizing of these in service provision by the CMO, FSO, MRSS and to a degree by the YCM agencies. The challenges to case management best practices are related to capacity issues, transition challenges, service continuity, dual case management, family-focused service provision, and the necessity of local systems crafting creative “work arounds” to get the needs of children and families met.

## Recommendations

In keeping with an evolutionary approach, DCBHS and its county partners should consider an effort to right-size and stabilize with a focus on implementing care and case management as intended and minimizing barriers to timely, effective care and case management services. What follows are a series of recommendations that require both leadership and extensive partnering with representative system partners at the county level.

First, consider localizing CSA review functions and minimizing the revolving assessment door, especially for step-down services. With respect to localizing CSA review functions, review the implications and practicalities of assigning CSA personnel who make level of care decisions to specific counties and perhaps to specific county structures. Even if a geographic assignment is not feasible, a virtual county assignment could be tried via web cams, teleconferences, along with required attendance at some county meetings. This change might increase felt and actual accountability to the county, allow county key stakeholders to get to know, appreciate and receive accurate and timely information from the CSA, and aid CSA staff in understanding the range of resources available in their assigned counties. It also would make the evaluation of and accountability for communication and adherence to guidelines person specific (e.g., the assigned CSA person(s) for that county and SOC partner accountability) rather than system focused (e.g., the overall CSA component, the CMOs, the YCMs). This might make problem-solving, communication, mutual respect, and trust more likely to evolve with a focus on fixing the problem rather than fixing the blame.

With respect to minimizing the revolving assessment door, consider having step-down service decisions occur solely at a local/county level with reporting of the information to the CSA for authorization, auditing, and data collection purposes but leaving the decision-making to the local entities. While there may be some concern about the downward substitutions of levels of care that are not appropriate, if family members, the current provider and the receiving service provider sign off on the plan, this might be less likely. Rapid cycle feedback could be built into the process to detect and remedy emerging problems in this *innovation zone* process.

Next, conduct an in-depth analysis of the current effectiveness of CMO and YCM services under current circumstances with respect to outcomes and process data for youth who meet CMO level of service criteria. It may be possible to match youth in the YCM “Shadow CMO” category (see **Figure 1**) with youth who actually receive CMO services in order to analyze the similarities and differences in their trajectories, service costs, satisfaction with services,

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permanency, ability to be served in less restrictive settings, etc. A similar but separate set of analyses should be done for youth who are in residential placements at the time of their referral to both systems.

Currently, there is good anecdotal and some county-level data that indicate that CMO services to youth with the most complicated needs allows youth to be served in their homes and communities and to make significant gains based on CANS data. However, from the perspective of the independent assessment there is a need for both process (e.g., actual vs. authorized service provision) and outcome data regarding school, home, and community functioning and placements. In particular, there is a special need for an analysis of process and outcome data for youth residing in residential treatment and other out-of-home settings at the time of referral. Frequency of contact, treatment planning input and activity related to the plan, and outcome data need to be analyzed for CMO *qualified* youth who receive CMO services and for youth who receive YCM service by default.

This analysis may be helpful from two perspectives. First, it will help the system understand the degree to which intensive care management is possible in terms of service delivery and the degree to which low caseloads and different service authorization packages are correlated with outcomes. Given the concerns of diverse stakeholders regarding the lack of appropriate residential services for the most difficult children, it is not clear that a case or care management approach would be able to impact length of stay or outcomes for youth in residential placements at time of referral. Indeed, it may be more cost-efficient to provide minimal case management for these youth (e.g., transportation for family members, attendance at team meetings, treatment plan input and advocacy) until the youth is in a transition planning phase (e.g., 90 days prior to the projected discharge date). At that point, intensive care management would need to be geared up to get community, school, and family-based supports in place and to begin the transition plan (e.g., post-placement visits, testing required by schools, transportation, and therapy). It also may identify facilitators and barriers to effective treatment and transition planning by the residential providers.

These data also would be important for decision-making related to caseload size, blended caseloads and the development of a single case/care management entity. However, there is likely little to be gained and much to lose by testing the development and operation of single case management structures unless the capacity issues are effectively addressed. If there are 20 chairs in a game of musical chairs and 30 people who need a seat, it matters little if there is one circle of 20 chairs or two circles of ten chairs. In a “right size and stabilize” process, the first problem to be tackled is capacity in conjunction with an analysis of effectiveness of different types of case management.

If, after addressing capacity issues, there is a decision to try out and evaluate a single case/care management entity, we would offer the following process recommendations:

- Preserve CMO caseload ratios for the children with the most intensive emotional problems and their families residing in the community. The work of knitting together an effective array of services, dealing with crisis, and engaging and working with families as partners is a daunting task that is only possible when caseload size is small.

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- Consider higher CMO caseload ratios (never greater than 1:15) only if the data on CMO referred youth who are in placement at time of referral indicates that this is warranted and that these youth require less intensive services prior to transition planning. It will be critical to ensure that care management preserves the necessary structural and operational features that enable the youth with the most challenging needs to be served in the least restrictive settings with their families and in the community.
  - Preserve stand alone case/care management structures to help ensure that families are receiving what is needed rather than what is most easily accessible or fiscally advantageous to the agency. This seems particularly important in a system that is perceived to be strongly provider driven rather than driven by the needs of children and families. A stand alone entity also may improve adherence to and operationalizing of system of care values, philosophy and principles. Such adherence and practices appear to be quite variable with the Youth Case Management services that are part of larger provider agencies. These larger agencies, often housing a range of services, reasonably have broader mandates, their own culture, values and ways of work that may or may not be compatible with SOC.

In summary, there is a solid base of services and structures to build upon and a system of care that would be the envy of many states when it comes to children's care management services. Evolution not revolution is recommended and adherence to overarching development principles is probably more important than adopting any of the specific recommendations. ■

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# Chapter 5: Service Array

## Research Question:

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- Is the service array responsive to the identified needs of children and families?
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## Introduction

In developing systems of care, improving and increasing the range of services available to youth and families is an essential process in the development to ensure that services can be individualized and that the system is child and family focused, community-based and culturally competent. In addition, several guiding principles for system of care stress the importance of the availability of comprehensive services to meet the needs of consumers in an integrated fashion within the least restrictive environments and without regard to child characteristics such as race, religion, disabilities, etc (Stroul & Friedman, 1986). In regard to developing service arrays within communities, Pires (2002) delineated three key principles:

- Service array encompasses access, appropriateness, and effectiveness of existing available services intended for children and families.
- Stakeholders from both state and local levels need to have a voice in structuring the service array.
- A broad array of services and supports includes both traditional and non-traditional services and supports, and clinical services and natural supports (p. 40)

In keeping with the above principles, the Service Array Assessment explores issues regarding New Jersey's definition of its target population, accessibility to services, the availability and appropriateness of services for specific populations of youth, gaps in the local service array, and potential outcomes for youth and families.

## Current Status and Background

As illustrated in The *Children's Initiative Concept Paper* (State of New Jersey, 2000), the goals set forth for the Children's Initiative were to restructure the publicly funded system that serves troubled youth. The paper calls for using resources to appropriately expand and make available tailored services to meet the needs of individual children. This would allow timely access to a broader array of services and resources. By providing a wider array of services that can be delivered in the home or community, the child's relationships with the family, school, and community are preserved.

One primary goal set forth in the *2000 Concept Paper* was to offer alternatives to residential care for children and increased access to intensive community services to support treatment and recovery and produce positive outcomes. At the time, the current Medicaid services available to children with emotional and behavioral health issues included acute inpatient hospital services, residential treatment care, outpatient treatment, and partial care.

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To increase and expand services to youth, the goal was to add as Medicaid reimbursable services: assessment, mobile crisis/emergency services, group home care, treatment homes/therapeutic foster care, intensive face-to-face care management, intensive in-home services, behavioral assistance, wraparound services, and family-to-family support.

To a great extent, the goal of expansion of the service array has been reached. All of the above listed services are present in the current service array although not always available to individual children and families. The expansion of services, however, gained further momentum once the findings of the *Office of the Child Advocate Report, Arthur Brisbane Child Treatment Center Investigation: an Examination of Conditions of Care and Recommendations for Reform* (Logosso & Sabin, 2004) were published and experts recommended the closing of the treatment center (and a decreased reliance on residential care) and a focus on community-based best practices to support systems of care. In addition, the child welfare reform plan mandated the rapid expansion of several services (such as Family Support Organizations) across the state. According to some study participants, the child welfare reform plan re-energized the children's behavioral health system into action after what seemed to be a lull in implementation.

However, despite the expansion of services, reportedly there are still some services that are not available and major gaps in service have been identified. In addition, the findings identified various populations that are perceived to be underserved in the system. The remainder of this section reports on the target population definition, key service array findings, including the strengths and weaknesses of the service array, the appropriateness of existing services, underserved populations, identified needs, strengths and recommendations. It is important to note, the perceptions of the service array presented in this piece of the assessment are those of focus group and survey participants working within the system. The perspectives of families receiving services are included under Chapter 8.

## Definition of the Target Population

The DCBHS Home Page, on the New Jersey Department of Health and Human Services web site, shares that DCBHS "serves children and adolescents with emotional and behavioral health care challenges and their families across all child-serving systems." *The Children's Initiative Concept Paper* (State of New Jersey, 2000) included a section on the target population to be served in the new system of care:

"The Children's System of care will address all children with emotional and behavioral disturbances and their families across the DHS child-serving systems, including children eligible for child welfare, mental health and/or Medicaid services ages 0–18 and youth 18–21 transitioning to the adult system. Child and family need will dictate the services received and the intensity of care coordination." (p. 8)



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In July 2006, DCBHS's Office of Policy, Planning, and Quality Assurance shared the following definition of the target population for DCBHS:

"The Children's System of care will address all children with emotional and behavioral disturbances and their families served by the Department of Human Services child-serving systems, including children eligible for child welfare, mental health and/or Medicaid/NJ KidCare Plan A (sic) services, ages 0–18 and youth 18–21 transitioning to the adult system. This includes children who may also be involved with the juvenile justice system or receiving substance abuse services in addition to their involvement with a DHS agency or contract provider. Child and family need will dictate the services received and the intensity of care coordination. For some children service decisions will also involve the Courts, public safety needs and statutory mandates."

Both of these definitions are actually broader than the Federal Definition for Serious Emotional Disturbances, which is utilized or adapted by many States for their definition of children and adolescents (hereafter often referred to as children) served through State Mental Health Authorities. The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) in 1996, defined children with SED as persons:

- from birth up to age 18;
- who currently or at any time during the past year;
- have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R; and
- that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Researchers base their estimates of numbers of children and adolescents requiring services in specific geographical areas on the definition of serious emotional disturbances (SED). Lezack and Macbeth (2002) cite a number of research efforts aimed at determining prevalence of SED:

- A 1996 CMHS workgroup found estimates of between nine and 13 percent among children ages nine to 17; for those with a greater level of functional impairment, a range of five to nine percent was found; It is interesting to note that the workgroup recommended that the higher number be utilized for planning purposes and the group found a higher prevalence rate of serious emotional disturbance among children from low socioeconomic backgrounds.
- "The National Mental Health Association estimates that one in five children and adolescents may have a mental health problem; at least one in 10, or as many as 6 million young people, may have a serious emotional disturbance."
- "The Surgeon General's Report on Mental Health (1999) notes that the Methodology for Epidemiology of Mental Disorders in Children and Adolescents (MECA Study) estimated that almost 21 percent of children between the ages of 9 and 17 had a diagnosable mental or addictive disorder with at least minimum impairment. The



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estimate decreased to 11 percent when a significant functional impairment was required, and to five percent when extreme functional impairment was the criteria." (Manderscheid and Sonnenschein, 1996).

In New Jersey's Community Mental Health Services Block Grant Application for Fiscal Years 2005–2007 (New Jersey Block Grant Application p. 106, 2005), a mid-point for the federal estimation methodology promulgated by SAMHSA was utilized for planning purposes:

"Using the federal methodology for estimating the prevalence of SED among children and adolescents and selecting eight percent, the midpoint of the two ranges of SED presented in the methodology, which are based on level of functioning, yields an estimate of youth with SED in New Jersey of 74,614. .... youth between the ages of eight and eighteen. .... The Division of Child Behavioral Health Services recognizes that the federal estimation methodology does not take into account youth between birth and eight. However, DCBHS considers the five to eight age group in planning the Child Behavioral Health Services System and will be developing strategies with the Division of Prevention and Community Partnership to identify youth at risk under the age of five and to make appropriate services available."

Stakeholders interviewed shared that more specific definitions for the target population were not included in written information about the reform efforts in 2000, or subsequent official documents, because of "the influence of the specific stakeholders engaged in advocating for the children's mental health system at different times in the development process", and "because of political climate issues".

Many national and local stakeholders support the use of a broader definition than the federal definition for serving children with mental health issues. One rationale is specific to children involved in the child welfare system whose family and community stressors are often very high. Advocates argue that "at least some children in this group may not always meet specific criteria for SED, but long term and intensive behavioral health supports are required." Another rationale is the reality that, for some children, "the very supports they require to remain functional in family, school and/or other community settings are at risk of being discontinued once a child's functional level improves and they no longer meet the definition of SED." Other professionals argue that "these types of services fall in the realm of prevention services", and are not the purview of State Mental Health Authorities. These issues and others (e.g., State financial resources available) are considered when States define their target population. For instance, in 2004 the Minnesota Department of Human Services, Division of Children's Behavioral Health implemented a new Medicaid reimbursable service intervention, Children's Therapeutic Services and Supports, a flexible package of mental health services for children who require varying levels of intervention. These new services enable a broader group of children to be served than the previous array of mental health services, expanding the Minnesota target population definition to include children with behavioral and emotional issues (Interview, Gweneth Edwall, August 24, 2006).

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DCBHS has established well-developed criteria for admission into different services. The criteria is based on mental health functioning and information and does not exclude children based on their referral source (e.g., child welfare, juvenile justice).

In New Jersey's Community Block Grant Application (New Jersey Block Grant Application pp. 112–113), a focus on outcomes is provided:

"The system of care described above is intended to be accountable for concrete outcomes that reflect the Department of Human Services' commitment to maintaining ties among children, families, and communities while delivering effective clinical care and social support services for children with emotional and behavioral disturbance. Desired outcomes include:

- Improved clinical outcomes and emotional/ behavioral stability.
- Improved permanency in community placements.
- Reduced lengths of stay in residential care.
- Reduced re-admissions to acute psychiatric hospitals.
- Improved crisis management and stability in living environments for families and caregivers.
- Improved educational performance and overall social functioning for children.
- Reduction in delinquent behavior among youth involved with services
- Improved satisfaction and increased participation in treatment by families and children.

In addition to these global outcomes, each child and family's individual service plan will target specific functionality in major life domains."

These outcomes are noteworthy, consistent with the original outcomes identified in the Concept Paper (State of New Jersey, 2000) and with best practices in other states (i.e., Arizona: success in school; live with family; avoid delinquency; and become stable and productive adults). It is interesting to note that most stakeholders interviewed did not reference outcomes in their discussions about the behavioral health system and did not reference documents that referred to these system outcomes. Additionally, stakeholders could not identify DCBHS documents that were available to the public that measured progress in meeting outcomes.

In summary, New Jersey's definition for the target population of children to be served by DCBHS is broader than the federal definition. Although New Jersey's Community Mental Health Block Grant application employs language more consistent with the federal definition and, for planning purposes, makes use of federal estimation methodology, it does not appear that written information from the block grant is widely shared with providers to guide clinical care. DCBHS has, at least for some services, well-developed clinical criteria for admission. Stakeholders shared that DCBHS has not effectively or widely shared, or stressed, the importance of working to achieve specific desired outcomes in working with children and their families, or effectively or widely shared data on the success of the system in meeting desired outcomes.

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## Access to Services

As noted earlier, the Contracted Service Administrator (CSA) is the single point of access to services or the “central gatekeeper”, with the responsibility of screening children, assessing them, and referring them out to the appropriate level of care. From there, the CSA or care/case management entity’s responsibility is to find the most appropriate services for children based on their identified needs. This assessment and referral process was meant to alleviate any inequities in service access as children’s needs would be matched with appropriate services.

However, focus group and interview participants suggested that there are other pathways to service that lead to inequalities in access. In particular, participants noted that both DYFS and Juvenile Justice have access to more services or higher level of intensity of services, and/or the ability to bypass certain aspects of the system. For example, a child placed in youth case management (YCM) may not be eligible for the same services as a DYFS child: “I have some kids that need a particular service, but because they are a YCM kid and not a DYFS kid, they can’t access that service. And it doesn’t make any sense.” Judicial focus group members in particular were frustrated by the fact that all services are not universally available to all children and the “label” attached to child, such as YCM, CMO, DYFS, determined the types and intensity of services that could be accessed for the child. In particular, they named services for substance abuse and developmental disabilities as missing. To reiterate this point, one stakeholder interviewee, made the comment that, “Access to services really depends on the referral source, and that often times there are no differences between the children who get certain services”. CMO focus group participants also expressed frustration of not having access to the same types of services DYFS had available for child welfare involved children, most notably emergency shelter and foster home beds. In summary, service priority and preference are afforded to some children in need of behavioral health services when in reality, in a system of care all children and families need ready access to individualized services and supports.

## Service Availability and Identified Gaps

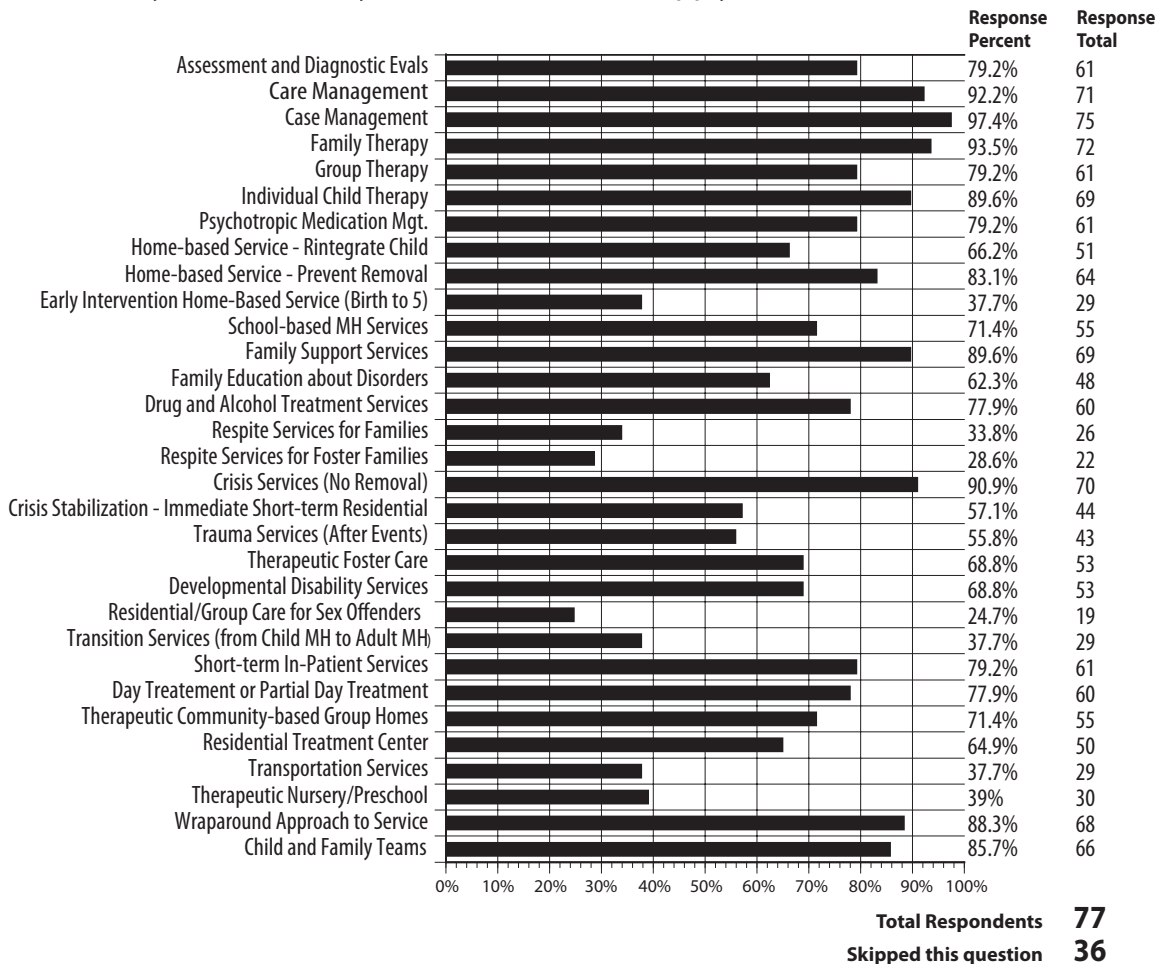
### Available Services

While New Jersey has been successful in expanding the overall services available to youth and families, focus group participants and survey respondents identified several gaps in services provided in local arrays. In regard to overall service availability, survey participants were asked a series of questions pertaining to the array of services in their community/county. As seen in Figure 3 below, survey respondents were asked to identify the services that currently exist in their respective communities. It is encouraging to note that the services most often found in communities (where 80% or more respondents indicated the existence of the service in their community) were primarily those services targeted for Medicaid expansion in the original *Concept Paper* (State of New Jersey, 2000) thus indicating the success of that aspect of the initiative.

**Figure 3.**

**Availability of Programs and Services**

1. Please review the programs and services below and indicate those that currently exist in your community. Please check all that apply



## Service Gaps

**Figure 3** above also shows services identified by survey participants that are not widely available including residential/group care for children who have committed sexual offenses, respite services for both biological and foster families, transition services to the adult mental health system, and transportation. Overall, when asked to indicate their level of agreement with the following statement: “The array of services in my community is adequate for meeting the needs of children and families”, only 21% of the respondents strongly agreed or agreed while the majority (70%) disagreed or strongly disagreed.

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In all, over multiple focus groups and interviews, participants listed the following service needs:

- Services for children with Developmental Disabilities
- Services for children with Substance Abuse Problems
- Spanish speaking clinicians
- Child psychiatrists
- Increased trauma services
- Respite and after school programs
- Short-term emergency beds without restrictions
- Services for children who have set fires,
- Services for children who have run away,
- Services for children who have sexually offended others, and
- Services for children who have committed assault.

In addition, survey results indicated that two-thirds of participants strongly agreed or agreed that families requested services that were not available in their community (only 17% disagreed or strongly disagreed). These responses indicate that the essential services needed to support all children are not available in local service arrays and that the continued expansion of services is needed.

## **Underserved Populations and Appropriate Use of Services**

Survey and focus group respondents noted several populations that have specific needs that are not being met by the current service array. In focus group and survey responses, participants revealed that service array/providers could not "...serve fire setters, sex offenders, children with personality disorders, children with parents that have emotional disorders, co-occurring MH and substance abuse issues." Of the sixty-six participants commenting on needed services, over half indicated that children who have set fires were excluded from services. In addition children with substance abuse disorders, children with developmental disabilities, and children who have committed sexual offenses dominated the list. Survey findings corroborated the above focus group responses with only one-fourth of survey respondents indicating that residential/ group care for sex offenders was available.

Further focus group discussion revealed that artificial capping of CMO organizations limits the number of open slots, thereby reducing the number of children in need of CMO service who gain access to the service. As discussed in more detail in Chapter 4, children eligible to receive CMO services are typically referred to YCM when there are no CMO slots available, however, YCM cannot provide the same type of services provided by CMO nor maintain the level of intensity required to meet the needs of youth and families.

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According to Judiciary focus group members, as a consequence of the lack of appropriate services, there is a system-wide phenomena referred to by one focus group participant as “pigeon holing”: “In this system, the system is still pigeon-holed. And, if a kid doesn’t fit into the pigeon hole, then the kid doesn’t fit for a while until they, until the system finds a pigeon-hole to put the kid into.” To sum up, one respondent noted, “If you call the CSA, you get the available services, not the ones that you need.”

The lack of certain services and the artificial capping of CMO services was said to be resulting in problematic practices by residential providers. As a consequence of the scarcity of services and artificial service caps, it was suggested by four different focus groups that some residential providers are “cherry picking” or only serving children that have less intense service needs. As noted by one focus group participant, “you don’t understand how, that the children that have the highest needs for services are the ones most likely to get rejected [from a residential placement]. And that does not seem to be a very good system in terms of finding placement options.” Respondents repeatedly conveyed that, “Children often get discharged from agencies [residential] due to the same behaviors that they were placed for.” Judicial focus group members adamantly felt that some residential providers were misrepresenting the services they were willing to provide for youth and families in order to gain multiple referrals and selectively choose youth that would be the least difficult to serve. Participants from diverse groups suggested that the current system is driven by residential providers who exclude certain high-risk populations and choose to serve the children with the least intensive needs. In turn, participants in a residential provider focus group discussed the difficulty of providing services when beds would be held for children only to have their service plans change suddenly or, in the cases involving juvenile justice, have judges require residential placement only to then suddenly change plans for youth. The difference in perspectives may reflect the lack of collaboration that occurs across departments and other system entities which would make understanding the rationales and behaviors of other system partners difficult (see **Chapter 1**).

## **Provider Profiles**

Survey respondents were asked to indicate how well the descriptions of services provided by residential provider agencies actually matched the services available. Almost one-half (44%) of respondents felt that the descriptions matched sometimes while 37% felt the descriptions often matched. None of the survey respondents indicated that provider service descriptions always matched available services. These results are significant considering that accurate and consistent provider service profiles are critical for an efficiently functioning system, especially for a system with a single point of access that is charged with making transitions smooth and timely. Focus group participants also were concerned about the differences between the provider profiles utilized by the CSA and the ones produced by the providers themselves. Participants indicated that the inaccurate CSA provider profiles led to confusion regarding



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exactly which providers were performing which services and in turn frustrated providers when youth were repeatedly referred to them for services they did not provide (e.g., receiving a referral for 10-year-old when the agency serves youth ages 13 to 17).

A lack of needed outpatient capacity was seen as leading to the overuse of Intensive In-Home Care and Behavioral Assistants (IIC and BA) services. Focus group participants expressed that IIC was being used as “the” treatment due to the abundance and availability of IIC providers even when children did not require those services. In particular, diverse focus groups decried the lack of outpatient services as providers shifted to IIC and BA services due to improved funding formulas. The overuse of IIC was seen as a direct result of the lack of other services available to youth and the ease in which IIC services could be developed by providers and authorization obtained.

## **Service Provider Quality and Accountability**

Intensive in-home services and supports are essential components of a service array within systems of care. However, an issue that was discussed in almost all focus groups and interviews was the lack of specificity regarding selection criteria, credentialing, supervision and accountability for Intensive In-home Care (IIC) Providers and Behavioral Assistants (BA). With regard to the practitioners’ training and qualifications, it was reported by one MRSS director that many practitioners are considered per diem employees and that the majority are generalists. There was a concern that some generalists may not have the appropriate skills needed to provide services to children with high-end needs and that inexperienced provider were not providing clinically sound services to children.

Focus group participants expressed concern about the lack of required training, skills, and an identified range of responsibilities for IIC and BA providers. Considering that IIC and BA is the predominant service available to many youth with serious mental health problems, participants were very concerned about the quality of these providers. In terms of the IIC provider organizations credentials, there is not a mandated accreditation process for IIC service. It is important to note, however, that both VO and UMDNJ interviewees shared that the training guidelines, credentialing and qualification guidelines, etc. have been developed for IIC-BA providers and were finalized in January 2006.

Stakeholders also expressed concern regarding supervision and monitoring of IIC Providers and the potential negative consequences for children and families. Despite the policy that the Child Family Team should monitor who receives these services, for how long, and service outcomes, participants discussed the perception of lack of accountability and oversight. One focus group participant expressed their concern stating:

“...that also brings up an issue in terms of who’s monitoring the IIC providers. The state says their Medicaid eligible, but no one’s really monitoring them. And then there’s a form that they have to complete, the families signs off



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on but I know.... There have been a lot of providers who, you know, were doing unethical things, taking clients home with them, among other things. And we're told through VO that this is not an unethical issue, so it kind of makes us leery in terms of who we're contracting with."

Overall, focus group participants pushed for more systematic mechanisms for ensuring accountability and oversight for IIC providers. As it stands now, MRSS directors do their best to monitor IIC Providers while they are providing services to children being stabilized after crises, as required in the MRSS contract responsibilities. As a result of the monitoring process, MRSS reported "weeding out" some IIC-BA programs based on their experiences over time and carefully choosing providers to serve children. Another concern of MRSS providers was that, while IIC providers engage in treatment planning with MRSS, the types of services provided by IIC are uncertain. MRSS does not necessarily know what the IIC provider will be doing with the child to meet treatment plan goals.

## **Service Impacts on Youth Outcomes**

While service level outcome data was not available for this evaluation, throughout the assessment stakeholders' perspectives and comments do provide a glimpse of the problematic outcomes associated with service array and access issues. Comments and perspectives such as "out of state placements are increasing", and youth are "recycled" through the system indicate negative outcomes for youth. In addition, multiple focus groups indicated that children with developmental disabilities and behavioral health issues likely are not receiving appropriate services and have very uneven and minimal access to care/case management services to address their needs. These children with special needs, dual diagnoses, permanency issues, or disengaged families have difficulty exiting the system and/or find themselves in holding patterns as they await services (see Figure 2 in Chapter 4: Care Management).

## **Strengths**

There are several strengths in the development of the children's behavioral health service array. The intended expansion of services set forth in the *Children's Initiative Concept Paper* (State of New Jersey, 2000) has been completed and youth and families now have access to numerous services that did not exist prior to 2000. In fact, given that the last round of CMOs to be implemented began providing services as of January 2006, at this point in time the system may not be mature enough to assess service gaps and develop plans for expansion and/or re-allocation of existing resources. Considering the number of services that needed to be implemented on a state-wide scale, New Jersey has been able to accomplish a great deal in five years on a scale that is virtually unprecedented in the nation.

An additional strength of the system is the level of consistency and agreement by system partners regarding service gaps. Study participants were very clear, and very much in agreement as to the services that were currently missing. In addition, participants were in

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agreement about specific underserved target populations. With system partners having this level of consensus, essentially the first step in service expansion (identifying gaps) is well on its way to completion at the local level. Findings would suggest that system partners would be ready to move into system/state collaboration to begin planning for service expansion and/or contracting strategies to re-allocate current service dollars.

As discussed in the following chapter, providers have also begun to bring evidence-based practices to local communities to better serve the needs of youth and families. Focus group participants from the following counties — Bergen, Camden, Cumberland/Gloucester/Salem, Middlesex, Morris, Passaic, and Union — indicated that providers were using evidence-based programs (practices or programs that can be found in a national registry of evidence-based programs). While this effort is not yet widespread, the recognition by some providers that evidence-based practices and programs can be effective for addressing the needs of specific populations is a positive step towards expanding the service array. In addition, a majority of survey participants indicated that their organization or their community expressed interest in utilizing evidence-based practices. This level of awareness, and potentially *buy-in* at the community level, will be critical to the expansion of services.

Additionally, many participants felt that collaboration at the local level among CMO, FSO, YCM, MRSS, and other providers was very good and that system partners were truly doing their best given the current constraints in the system. System partners were dialoguing and problem solving with one another to resolve service problems and develop new strategies to ensure that youth and families were receiving the best services possible. In summary, it was expressed that each system partner has its strengths and has shown significant improvements in relationship to the implementing the new service array to benefit children, youth, and their families.

DCBHS and the CSA have also been making progress in reducing the number of youth in out-of-home placements. Through an initiative funded by the Annie E. Casey Foundation, beginning in 2005 CSA has defined discharge criteria for children in out-of-home placements and focused the attention of care and case managers on identifying barriers to discharge. As reported by the Center for Health Care Strategies (2006) as of February 2006, 85% of youth that had been identified through the New Jersey initiative have been able to return to their communities and/or families. Currently, CSA hopes to identify approximately 300 children per quarter in out-of-home placement in need of comprehensive discharge planning.

## Recommendations

In recent months DCBHS has put a priority focus on developing clinical standards of care. Inherent within clinical standards are matching appropriate services and supports for specific populations. As part of the process of developing clinical standards of care, DCBHS plans to also revisit its target population definition. Several recommendations follow below, one specific to the definition of the target population, as well as recommended activities that build upon the definition (see bulleted list below).

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It is recommended that DCBHS review, and if necessary, update their definition to clearly specify the population of children in New Jersey for whom the Division will provide services. This final definition should be promulgated in regulation and shared with all stakeholders involved in the child behavioral health system. The final approved definition should be subsequently used for reviewing admission criteria into all of the different services and supports offered by the DCBHS. If DCBHS is to serve children from 0 to 21, it is recommended that best practice standards for different age groups (e.g., 0 to 5, 6–10, 11–14, 15–17, 18 to 21) be developed, with the standards identifying the array of services and supports available for each age group.

1. Best practice standards (a.k.a. Clinical Guidance Documents or Practice Improvement Protocols) for specific populations should also be developed (e.g., children in the child welfare system, youth requiring both mental health and substance abuse services, children requiring both developmental disabilities and mental health services).
2. As shown below in the Sample Framework, DCBHS should develop, revise or update a list of core values, with the intent that each service offered by DCBHS fully operationalizes these core values.
3. DCBHS should develop, revise or update a set of desired outcomes for children served through DCBHS services and supports, and develop, revise or update specific desired outcomes for each service/program type, including these outcomes in performance based contracts with providers.

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### Sample Framework for Building an Array of Services and Supports

- **Develop a Clear Definition for their Target Population** to be served.
- **Establish core Values** which will be fully operationalized in all services and supports;
- **Identify clear Outcomes that will drive the delivery of all services,** system wide and/or for individual program types;
- **Establish Best and Evidence-based Practices/Programs for Services and Supports for discrete Age Populations** within the target Population (i.e., a range of early childhood services for children 0 to 5);
- **Establish Best and Evidence-based Practices/Programs for Services and Supports for Discrete Populations** that cross over different age populations (e.g., substance abuse, developmental disabilities);
- **Develop clinical Standards/Best Practice Protocols for serving Discrete Populations** (e.g., children who have experienced serious trauma, children involved in the child welfare system);
- **Within the Clinical Standards, establish Assessment and other Evaluation Tools/Instruments** that can be used to ensure that the targeted population, and discrete sub-categories of this population, have access to the designated Services and Supports defined as Best or Evidence-based Practice for each sub-category.
- **Develop Performance Based Contracting** with all providers for all service types that includes defined outcomes and best practice expectations.
- **Utilize national Prevalence Estimates, as part of Determination Process, for Estimating amounts of Different Services and Supports** required statewide and within different catchment areas.

- 4) The service array is not meeting the needs of all the youth enrolled in the system. Participants listed several services that are missing and populations that are being underserved. As mentioned above, the consensus of participants on needed services, and the introduction of evidence-based programs in some communities indicate that system partners at the local level are ready to engage in collaborative efforts with the state to expand the service array. The local and state systems would benefit from collaboratively engaging in the exploration of evidence-based practices and programs, and resources and funding mechanisms to support services expansion.
- 5) The needs of specific target populations should be addressed. Study participants repeatedly stressed that children with developmental disabilities and mental health problems, children who are dually diagnosed with mental health and substance abuse, fire setting and sexual perpetrating behaviors were in critical need of services.

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Friedman et al. (2005) identified two sites that were recognized by national experts as providing good systems of care and effective services for challenging populations: Milwaukee Wrap-Around and Westchester County, New York. The challenging populations served by these two sites include sexually reactive children and youth, youth who have committed sexual offenses, dually diagnosed adolescents with developmental disabilities and mental health issues, and youth who present serious risks to the community, such as juveniles who set fires. Core functional elements of these successful efforts include strong community networks that are inclusive of all service domains, efforts to reduce the stigma of serving some of these children in the community (e.g., children who have set fires), the use of community planning teams, family involvement at the program development level, investigation of the research base related to effective interventions, meetings with researchers and visits to successful programs in other states, and ongoing data collection regarding service and intervention effectiveness.

- 6) The number of children receiving IIC services, the IIC providers, and the exact methods of service provision utilized by IIC providers requires further assessment by the state and local communities. Immediate focus should be on directed towards increasing the quality of IIC services and providers and implementing the new training and qualifications guidelines. It is important to remember that IIC as an authorization code and as a service presently only tells where the services will be taking place (e.g., in the home); it is not a description or authorization of a particular modality of treatment in the home that matches needs of the child.
- 7) Data from service agencies, especially residential providers, need to be collected by an independent source, to determine if providers are in fact selectively rejecting or choosing clients. In addition, rates and rationales for unplanned discharges need to be examined carefully to determine the degree to which providers discharge children and youth for displaying the very behavioral problems that the agency is designed to ameliorate through treatment. In addition, it would be useful to identify current best practice residential providers in and out of the state and learn from their approaches and intervention strategies. Increasingly, residential providers are being requested to develop an array of services within their own agencies and to rely less on congregate care settings. National best practices in developing such continua should be sought together with best practices in residential services (e.g., Teaching-Family Model, Charley Programs).

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New Jersey's children's behavioral health system has successfully broadened the service array and positive changes are accruing for children, youth, and their families. Yet, there are a number of identified service improvements that need to be made as identified by system stakeholders. Even though there were a number of identified needs, stakeholders from all levels of the system were optimistic. While they stressed that the existing infrastructure was sound, collaboration with state-level leadership is needed to respond to community needs, including the expansion of the service array and attention to monitoring and improving service quality. ■

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# Chapter 6: The Use of Evidence-Based Practices

## Research Question:

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- Does the system include and/or promote the use of evidence-based and promising practices?
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“New Jersey practitioners and agencies seem not to be “clued in” to the benefits of EBP. There is no systemic expectation of funders/contractors that EBP should be the norm or a goal. Some clinical leaders may be including them in their agencies’ offerings, but knowledge of this is not widespread.”

— CMO Director

## Introduction

The use of evidence-based practices and programs in systems of care is considered to be one of many functions that must be planned, organized and implemented in a purposeful manner when building the system (Pires, 2002). As defined by The Institute of Medicine (2001) “...evidence-based practice is the integration of best research evidence with clinical expertise and patient values” (p. 46). In their study of service arrays, evidence-based practices and quality improvement in children’s mental health in Florida, Friedman, Drews, Blase, Fixsen, Paulson & Zusman (2005) defined evidence-based practices as “...well researched skills, techniques and strategies that can be used by a practitioner” (p. 51). The authors go on to define evidence-based programs as:

“...collections of practices that are done within known parameters (philosophy, values, service delivery structure, and treatment components) and with accountability to the consumers and funders of those practices. Evidence-based Programs represent well-researched ways to translate the conceptual, goal-oriented needs of program funders and agency directors into the specific methods necessary for effective treatment, management, and quality control” (p. 51).

The use of evidence-based practices and programs has gained popularity since the seminal article defining evidence-based medicine with a focus on both research and the consumer was produced by Sackett, Rosenberg, Muir Gray, Haynes, and Richardson in 1996 (Drake, Merrens, Lynde, 2005). At present, over 300 practices and programs are listed on approximately 33 registries, lists, and source documents as meeting some independent criteria for being evidence-based (Study of Model Evidence-Based Programs and Practices, 2005). The term “best practices” includes strategies and practices in human services that have been proven to be effective through experience and are commonly accepted in a field as attributing to positive outcomes and not causing harm to consumers. Best practices may be included on a national registry list, and designated as having a lower level of evidence but



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emerging or indicating promise, but a practice or program viewed as being evidence-based typically is supported by a rigorous research base, including the use of randomized controlled trials.

However, the evidence for any one practice or program only gives providers and practitioners information that helps them choose which to adopt to meet the needs of a specific target population, it does not provide information on how to install the programs within organizations or service arrays or how to implement the practices and programs once they have been installed (Fixsen, Naoom, Blase, Friedman, & Friedman, 2005). Installation is included in Fixsen et al. (2005) Stages of Implementation Framework which delineates six iterative stages for implementing innovations in organization/community settings. Activities during the Installation Stage are described as follows:

“Resources are being consumed in active preparation for actually doing things differently in keeping with the tenets of the evidence-based practice or program. Structural supports necessary to initiate the program are put in place. These include ensuring the availability of funding streams, human resource strategies, and policy development as well as creating referral mechanisms, reporting frameworks, and outcome expectations” (p.16).

Thus while careful attention to consumer needs in relation to practice/program effectiveness and evidence must take place in order to make the decision to adopt and evidence-based practice or program, purposeful planning must continue as organizations and communities work to successfully install and implement evidence-based practices and programs. Implementing evidence-based practices and programs is an involved, iterative process with full implementation (defined as practice/program has become the norm in the organization with full operation and all the needed complements in place to support it) of a practice or program taking between two and four years (Fixsen, 2005). All system partners involved in a system of care initiative beginning to install and implement evidence-based practices into the local service array must be prepared to invest ample time, funding for start up and maintenance, and supportive organizational flexibility, to reach full implementation and sustainability of the practices and programs.

## **Current Status and Background**

In order to consider the issues related to the implementation of evidence-based programs and practices, it is important to first review the implementation status related to New Jersey’s children’s behavioral health system. The implementation of the children’s behavioral health system is still ongoing in New Jersey. Sites (counties/vicinages) with less than 2 years’ experience would, by time alone, still be considered in the Initial Implementation Stage (of the Stages of Implementation Framework) indicating that the installation of the needed components has taken place but that the actual ways of work, practice, acceptance, and real world application of those components are still in process. For both newer implementing and more experienced counties/vicinages, the tumultuous political and children’s reform

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transitions that have taken place in current years have required ongoing implementation of new policies and procedures that have continued to alter the children's behavioral health system.

It is unlikely that any part of the system has been able to reach full implementation, let alone sustainability, in such a shifting atmosphere of policy and procedure change. This atmosphere of change and upheaval, coupled with current parameters that keep the system frozen at the initial implementation stage (such as the halt on expanding CMO capacity) has made it quite difficult to maintain the implementation momentum that would enable the system to reach the full potential of the intended design.

Included in the mix of implementing the children's behavioral health system components, some local system providers have also begun exploring, adopting, and implementing evidence-based practices and programs for inclusion in the local service array. As noted below, survey respondents from multiple counties/vicinages indicated that evidence-based practices and/or programs were used in the local service array. However, many survey respondents also commented on the lack of and need for evidence-based practices and programs in their community. Given the current implementation status of the overall system, the sparse, limited use of evidence-based practices and programs at this point would be expected. In addition, experts interviewed in the Friedman et al. study of evidence-based practices in children's mental health in Florida stated, "Only a few states are investing the resources (time, energy, funding) necessary to implement EBP's and programs statewide" (p. 55).

## Findings

Overall, when asked about the use of evidence-based practices and programs, CMO, YCM, FSO and MRSS focus group participants indicated that evidence-based practices and programs were not typically utilized in the service local service arrays. While a few participants mentioned that a particular practice or program (such as MST) was being offered by a provider, there was agreement that widespread adoption and implementation of evidence-based practices was not occurring. Survey respondents (excluding DYFS supervisor and Juvenile Justice Attorney participants) were asked to provide the names of any evidence-based practices and programs included in their current service array (36 participants responded). It is clear from the list below, that several respondents (n=10) were familiar with the term and were able to identify practices/programs that are currently considered to be evidence-based used. However, some respondents were unclear about what would constitute an evidence-based program or practice. The practices and programs identified by respondents are listed below; those practices and program currently listed on an EBP registry, indicating that they have met the criteria for the respective registry, are marked with an asterisk. It should be noted that only eight of the programs and practices listed meet that criteria.

- Multisystemic Therapy (MST)\*
- Nurse Family Partnership\*

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- Milwaukee Wraparound
  - PACT\*
  - Length of Stay/Recidivism
  - CMO, YCM, MRSS
  - Strengthening Families\*
  - Positive Behavior Support (PBS)\*
  - In-home Treatment
  - Dr. Ablon's "Working with the Explosive Child"
  - Cognitive Behavior Therapy\*
  - Child and Family Teams
  - Psychological First Aid
  - Needs Assessments
  - Rensselaer Institute
  - Healthy Families\*
  - Juvenile Fire Prevention
  - Modeling Positive Parenting
  - CMHS IOP/OP Treatment
  - Functional Family Therapy\*

The inclusion of programs/practices that would not be considered evidence-based indicates a lack of clear understanding as to what constitutes an evidence-based program. Survey respondents from the same counties/vicinages also showed inconsistency in reporting evidence-based practices/programs in their service array with some participants indicating that there were "none" (or as stated by one participant "There is nothing that even comes close to evidence-based practices here) while others from the same county/vicinage listed what they felt to be applicable programs and practices.

A review of the data by geographic area (counties and vicinages) did not show any differences related to status of implementation and the use and knowledge of evidence-based practices. Counties/vicinages that were in the initial cohort of the children's behavioral health system as well as newer counties/vicinages listed both evidence-based and non-evidence-based practices as being in use, indicating that the stage of implementation was not related to knowledge and use of evidence-based practices and programs. As indicated by focus group participants, counties/vicinages and community providers have individually taken on the responsibility of including evidence-based practices into the local service array as opposed to a systemic effort to bring evidence-based practices and programs to all communities and consumers.

It is encouraging to note that the climate seems to be right for introducing such initiatives and reviewing the financing and policy changes that would facilitate the uptake of evidence-based programs and practices. For example, 79% of respondents indicated that there had been support or interest on the part of their organizations for the use of evidence-based

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practices; two-thirds indicated that their communities were interested as well. As noted by one respondent, “This is a community that is very interested in implementing evidence-based practice and is educated about its importance.”

## **Barriers to Implementing Evidence-based Practices**

One barrier to the adoption and implementation of evidence-based practices and programs on a state scale is the lack of training provided to increase awareness of evidence-based practices/programs in general, and/or trainings pertaining to specific practices or programs. Survey participants were given the opportunity to respond to questions related to trainings provided for evidence-based practices. Overall, 63% of respondents had either not received any training, or were “not sure” if they had received such training.

Survey respondents also had the opportunity to list and provide comments on what they felt were the barriers and facilitators to implementing evidence-based practices and programs. The main barriers cited included cost/funding for evidence-based practices/programs, an understanding of the goals and purpose of evidence-based practices and programs, ability to train providers/system partners, resistance to change, and a resistance to being held accountable. Listed below is a sampling of comments related to barriers to implementation from survey participants:

- Funding to purchase the licensing rights and other fees associated that are not reimbursable
- Defining realistic goals
- It is new and not many understand it
- Training opportunities, applicability to the population served, lack of time to accomplish data collection; one size does not fit all
- Providers are resistant to change, resist accountability
- Evidence-based practices would hold CMOs, YCMs, MRSSs and Providers accountable. No one wants to be accountable.

The barriers listed above are not uncommon when attempting to bring evidence-based practices and programs to communities. In their study of service array, evidence-based practices and quality improvement in children’s behavioral health in Florida, Friedman et al. (2005) found that lack of funding and awareness, resistance and lack of motivation to change, and staff turnover were the current barriers identified by mental health program staff. As mentioned previously, adopting and implementing evidence-based practices and programs is by no means an easy endeavor and it will require a measured, purposeful approach over an extended period of time.

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## Strengths

The findings presented above indicate that the use of evidence-based practices and programs is already beginning in New Jersey. Over one-third of survey participants have already received some kind of training either in increasing awareness of evidence-based practices or on the components of a specific practice or program. Survey and focus group data also have shown that participants are aware of the need for missing services (such as child psychiatrist) in the local arrays and of specific target populations in need of services (children with fire setting behaviors; see Service Array Assessment). The awareness of consumer needs at the local level is the first step in the Exploration Stage of Implementation, whereby community stakeholders assess needs and seek out evidence-based practices/programs that will match both the need and the target population requirements of the program (Fixsen et al. 2005). As mandates, policies and communication between the state and local system becomes clearer and more functional (see Chapter 1), local systems will be able to collaborate with the state in identifying the target populations that might benefit from an evidence-based program or practice, the availability of such programs and practices, and the infrastructure and supports needed by providers and communities to add evidence-based practices to local service arrays.

Another strength in the area of evidence-based programs and practices is the development and utilization of Trauma-Focused Cognitive Behavior Therapy (TF-CBT) by Dr. Esther Deblinger and her colleagues, Drs. Judy Cohen and Anthony Mannarino. Dr. Deblinger is a licensed clinical psychologist and professor at the University of Medicine and Dentistry of New Jersey. In 2001 TF-CBT was given an “Exemplary Program Award” by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. In 2004 it was named a Best Practice by the Kauffman Best Practices Task Force of the National Child Traumatic Stress Network, and was given the highest classification for an evidence-based practice by the U.S. Department of Justice sponsored report, *Child Physical and Sexual Abuse: Guidelines for Treatment*. This New Jersey expertise, both in terms of intervention approach and replication procedures, may be useful to the state and counties as evidence-based programs and practices are more widely implemented.

## Recommendations

- 1) Review initiatives of other states to adopt EBPs. Several states are currently engaged in activities to implement evidence-based practices and programs on a state-wide scale. Friedman et al. (2005) developed a listing of states and activities which is included below:
  - Hawaii: widespread adoption of EBP’s and programs as part of their response to a class action lawsuit coupled with a statewide quality assurance system designed to support decision making at the practitioner, manager, organization, and systems levels.
  - Michigan: the use of a statewide evaluation system (based on the Child and Adolescent Functional Assessment Scale) to find sub-groups of children for whom treatment is not effective, then matching them to EBP’s and programs.

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- New Mexico: nearing the end of a two-year planning effort to align funding policies with the needs of EBP's and programs.
  - New York: "Winds of Change" statewide effort to encourage and support the implementation of EBP's and programs.
  - Ohio: established Centers of Excellence to help communities and provider agencies implement EBP's and programs and to evaluate their results.
  - Washington: emphasis within juvenile justice to provide more EBP's and programs and to evaluate their effects and collaboration of departments (JJ, CW, MH) in selecting evidence-based programs that meet the needs of children served by all three departments.
- 2) Continue to identify populations that are not well served by the current service arrays. The ability to identify unmet consumer needs and purposefully seek out, plan for and implement evidence-based practices and programs that meet those needs will be critical for service viability and for families and youth to have choices in service planning. As illustrated in Chapter 8, there is data available that will assist in the identification process.
  - 3) Choose evidence-based practices and programs carefully. As noted in the introduction to this section, there are multiple listings and criteria used to make determinations as to the evidence base for a practice or program. Listings and criteria should be reviewed thoroughly and the purveyors (organizations or individuals responsible for training, coaching, and providing ongoing support as implementation proceeds) of the program should be engaged before making the decision to adopt a program (Fixsen, et al. 2005). (See "Matrix of Children's Evidence-Based Interventions" for a listing of programs and practices (Yannacci & Rivard, 2006) located at <http://systemsofcare.samhsa.gov/headermenu/docsHM/MatrixFinal1.pdf>) as well as the listing of children's evidence-based programs and practices in Friedman (2006).
  - 4) Bringing evidence-based practices and programs to New Jersey needs to be done through state and local systems working together. As discussed under Chapter 1, local systems will be the key in identifying needed services and underserved populations while the state system's role in contracting, funding, outcomes and reimbursement mechanisms are key to supporting providers in making evidence-based practices and programs available to consumers.
  - 5) Collect data and information from those NJ providers already engaged in evidence-based practice implementation. This will provide first-hand learning about the facilitators and barriers to the process. In addition, providers finding success in implementation and positive outcomes for children and families might be in a position to coach others attempting to implement programs across the state. Highlighting their success could encourage more risk-adverse agencies to explore, adopt, and implement evidence-based programs and practices.
  - 6) Invest in implementation. As with any endeavor that involves bringing a new innovation into an organization, community, or system, implementation will require an investment of time, energy, funding, and measured, purposeful



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action. Underestimating the pace and needed supports required for successful implementation will lead to frustration, disappointment and negative outcomes for consumers. It is beyond the scope of this assessment to detail the frameworks, issues, and strategies that can lead to successful, large-scale uptake of evidence-based programs and practices. A synthesis of the implementation literature and information on implementation best practices can be found on the National Implementation Research Network websites at <http://nirn.fmhi.usf.edu>.

## **Suggested Resources**

The definition of the target population, in essence, drives the development of the entire service array. A number of new leadership team members within DCF and DCBHS expressed a desire “to move towards evidence-based practices”. This commitment makes it an ideal time to review and, if necessary, update the definition of the target population. From this definition, an array of best and evidence-based services and supports, based on best clinical practice and research, can be developed for appropriate sub-groups of the target population and monitored carefully during early implementation. Some existing best practices (e.g., wraparound, family and youth team meetings, care/case management services) may serve as foundation services, appropriate for most ages served within the target population. The clinical standards or best practice protocols under development by DCBHS, can be utilized to provide background information as to why different service arrays have been identified and implemented for specific sub-groups of the target population. These documents can also provide additional guidance, beyond the use of recommended specific services or programs, for specific sub-groups of the target population (i.e., for working with transitioning age youth, reference to research and documents that will provide family members, providers and advocates with additional information to guide their practice and understanding of the needs of this group of youth).

Another resource is consultation with, and review of documents developed by state mental health leaders from New York, Minnesota, Arizona and other States that have engaged in extensive work to research the appropriate service and support array of best and evidence-based practices for specific sub-groups of their target population.

The Arizona Behavioral Health System for Children and Families (ABHSCF), within the Arizona Department of Human Services, has developed a number of documents, called Practice Improvement Protocols, which include national standards and recognized best practices that address a range of child and youth needs (<http://www.azdhs.gov/bhs/jk.htm>). ABHSCF also has developed desired core principles, expectations for all providers regarding operationalizing family involvement, and expected child outcomes from services, which may all be of interest to New Jersey as they develop or refine their own core principles, provider expectations, and outcomes. See Appendix D for documents outlining Arizona’s core principles, family involvement expectations and desired child outcomes.



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The Minnesota Department of Human Services (DHS), Division of Children's Behavioral Health (DCBH), is building upon Hawaii's model of implementing a range of evidence-based practices for children's mental health. Minnesota has started with three different locally driven implementation models because of the desire to build voluntary cooperation and enthusiasm for the new framework, and evaluate different implementation models before expanding statewide. Eventually, Minnesota intends to ensure that every clinical staff in the State, providing Medicaid reimbursable services, will have access to the web-based application of evidence-based programs to inform the treatment plans of all children and families served (Interview with DCBH staff, Gweneth Edwall, August 24, 2006).

The New York Office of Mental Health, Division of Children and Families Services, has been involved in a statewide program improvement initiative to support out-of-home programs (i.e., residential programs) in operationalizing best practices. Towards this end, a list of desired outcomes for Residential Treatment Facilities was established. (See Appendix E for a list of desired outcomes for residential programs licensed by the New York State Office of Mental Health). ■

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# Chapter 7: Family Involvement as Partners

## Research Question:

- Are families involved as partners, at both the system level and in the delivery of services? How effective is the service system at responding to the needs of and delivering high quality behavioral health services to children with serious emotional disturbance (SED) and their families?

## Introduction/Background

Partnerships with families and youth at the service delivery is central to operating within a systems of care philosophy. Burns, Hoagwood and Mrazek (1999) offer a very strong statement in support of the importance of family engagement in treatment. They report that 'the effectiveness of services, no matter what they are, may hinge less on the particular type of service than on how, when and why families or caregivers are engaged in the delivery of care.'

## Method

A child and family quality review methodology was used that covered five domains of investigation adapted from Armstrong et al. (1998) and based on professional consensus of effective practice in children's mental health (Stroul & Friedman, 1986; Stroul & Friedman, 1988). The following table (**Table 12**) outlines the domains of investigation, indicators, and sources of data. The System of care practice review protocol (Hernandez & Gomez, 2002) was adapted to include pertinent measures of quality and was used as the data collection tool. Both caregivers and providers were asked the same questions about the assessment process, the treatment plan, the services and supports provided, and the outcomes for the child and family. Narrative summaries from the child and family quality reviews were analyzed for each domain of investigation and are presented within the research question framework.

<b>Table 12.</b> <b>Domains, Indicators, and Sources for Child and Family Quality Review</b>		
<b>Domains of Investigation</b>	<b>Indicators</b>	<b>Source</b>
<b>Effectiveness of the system</b>	<ul style="list-style-type: none"> <li>• Services are easily accessible and conveniently located</li> <li>• Cultural competency</li> <li>• Comprehensiveness</li> <li>• Service coordination</li> <li>• Families are supported</li> <li>• Services offered in least restrictive manner</li> <li>• Treatment plan goals are being met</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment plan goals are being met</li> <li>• Focus groups</li> </ul>
<b>Treatment planning</b>	<ul style="list-style-type: none"> <li>• Treatment plan reflects practice guidelines</li> <li>• Treatment plan is individualized and appropriate to child and family needs</li> <li>• Family involvement in design of treatment plan</li> </ul>	<ul style="list-style-type: none"> <li>• In-depth interviews</li> </ul>
<b>Quality of life</b>	<ul style="list-style-type: none"> <li>• Family stability and functioning</li> <li>• Child's functioning</li> <li>• Needed supports are in place</li> </ul>	<ul style="list-style-type: none"> <li>• In-depth interviews</li> </ul>
<b>Experiences with the system</b>	<ul style="list-style-type: none"> <li>• Parent perceptions related to:</li> <li>• Level of met and unmet needs</li> <li>• Level of improvement for child and family</li> <li>• Child and family engagement in treatment planning</li> </ul>	<ul style="list-style-type: none"> <li>• In-depth interviews</li> </ul>
<b>Experiences outside the system</b>	<ul style="list-style-type: none"> <li>• Presence and perceived success of informal supports</li> <li>• Involvement in other systems (e.g., school, juvenile justice)</li> </ul>	<ul style="list-style-type: none"> <li>• In-depth interviews</li> </ul>

A total of thirty primary caregivers and the corresponding CMO or YCM care coordinators were identified for interviews in three counties. The sample of children were selected by DCHBS using a randomized sampling process to identify children who were involved in more than one public agency as recorded in the ABSolut data base. The criteria included the

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child having a serious emotional disturbance that required the involvement of more than one public service agency including mental health, and DYFS or Juvenile Justice (or both). In addition, the child had an open case with a CMO or YCM during the final quarter of 2005 or the first quarter of 2006. Primary caregivers interviewed included mothers, fathers, youth, custodial grandparents, and one custodial aunt. In addition, DYFS guardians were interviewed as the caregiver when the selected child was in custody.

The child and family reviews were held in three counties: Union, Middlesex and Ocean. These counties were selected because they represent three distinct periods of integration into the system of care. Union County entered in the system of care during phase I, in 2001; Middlesex entered in phase II of implementation in 2003; and Ocean County entered the system of care in phase III of implementation, in 2005. Five interviewers from the child and family review team for the independent assessment conducted these interviews during June and July of 2006.

Primary caregiver refers to the individual who was identified in the role of parent, or the DYFS custodian. Face-to-face interviews were held with 18 primary caregivers who are family members of the child who receives services, and 8 DYFS guardians. One young adult youth was interviewed without a parent and is included in the total number of 18 caregivers. Two other youth participated in the interview with their parent. One interview with a primary caregiver (who had moved across the state) and one interview with a DYFS guardian (who had never met the child) were conducted via telephone. All other interviews with primary caregivers were conducted in the home, or in a community location chosen by the caregiver.

Provider interviews were held with nine care coordinators in Union County (five CMO's and four YCM's), seven care coordinators in Middlesex County (four CMO's and three YCM's), and nine care coordinators in Ocean County (six CMO's and three YCM's). In some cases, the interview was held with a supervisor when the staff member was no longer employed as care coordinator, and the case was closed. **Table 13** shows a breakdown by county of the interviews that were conducted.

<b>Table 13.</b>				
<b>Child and Family Review Interviews by County</b>				
<b>County</b>	<b>Caregivers</b>	<b>DYFS Guardians</b>	<b>CMO Case Manager</b>	<b>YMC Case Manager</b>
<b>Union</b>	6	3	5	3
<b>Middlesex</b>	7	2	4	3
<b>Ocean</b>	5	3	6	3

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## Findings

The findings for each domain are summarized across all respondents, and then presented by county, beginning with the county in late phase of implementation (Union), followed by Middlesex County (mid-implementation), and concluding with the most recently implemented site, Ocean County. The domains are family involvement in the assessment process, family involvement in treatment planning, and responsiveness of the service array to the identified needs of children and their families. Each section ends with a summary of the findings across counties.

### **Family Involvement in the Assessment Process, Including Use of the Strengths and Needs Assessment**

Across the 3 counties findings indicate that care coordinators are much clearer than caregivers and/or DYFS guardians about whether an assessment was done for an individual child. Twelve of the 26 family members and DYFS guardians often did not know whether an assessment had been done; and at times, reported that the results had not been shared with them. In contrast, most care coordinators reported that the assessment was used in the treatment planning process, and many were uncertain about whether families understand the results. Stage of implementation does not appear to be a factor in whether caregivers are involved in the assessment process, and the degree to which care coordinators believe that family members understand the findings from the assessment process. Findings regarding each specific county are provided below.

#### **Union County**

Four of the nine caregivers in Union County reported that an assessment was done to determine their child's needs. The other five caregivers (two were DYFS guardians) did not know if an assessment was completed for their child.

All nine YCM and CMO care coordinators reported that they completed Strength and Needs Assessments for the identified child, and that the assessments were used to assist in the treatment planning process. Seven care coordinators reported that the families understood the assessment results. One commented that the assessment results "can be intimidating" for families, and another perception was that families do not generally understand the results.

#### **Middlesex County**

Three primary caregivers in Middlesex County reported that an assessment of their child's needs was completed. One of these caregivers reported that the assessment results were not shared with the family. Another caregiver said that the assessment was completed in a residential treatment program. Two caregivers did not know if an assessment was done, and one caregiver believed that an assessment may have been completed prior to her receiving custody of the child. The two DYFS guardians who were interviewed as primary caregivers both reported that an assessment was completed.

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Six of the seven care coordinators from the Care Management Organization and Youth Case Management in Middlesex County reported that the Strength and Needs Assessment was completed. One care coordinator reportedly did not conduct an assessment because the primary caregiver denied services. The care coordinators all reported that they use the results of the assessment to determine the areas of need for the child.

Three care coordinators interviewed said that the families understand the assessment results; two were not certain; and one said that “planning begins when the family fully understands the assessment.”

## **Ocean County**

Three caregivers who are family members reported that a needs assessment for their child was done in the residential treatment program or in the hospital. Of these caregivers, one reported that the assessment was done by a social worker who observed the child, and one reported a “2-minute assessment” by a psychologist. Another caregiver said that the “child is in the hospital and I’m not sure what was done.” Finally, one primary caregiver specifically reported that the Strength and Needs Assessment was done, and that he/she understood it.

One DYFS guardian reported that an assessment was done by a caseworker and signed by a supervisor; another said that a psychological and social assessment was done for the child and that the assessment was used to measure strengths and needs. Another DYFS primary caregiver said that the needs assessment was done by the DYFS staff member and their supervisor without input from families, care coordinators or other agencies.

All CMO and YCM care coordinators in Ocean County reported that children receive strengths and needs assessments. The results are recorded in ABSolut, with the care coordinators responsible for administering the assessment. When asked about family understanding of the assessment process in planning services, three care coordinators responded that families often understand. Comments from four other care coordinators about family understanding of assessment results include: “They don’t normally understand” “No family involvement.” “Assessments are not completed with families.” And, “They have a hard time understanding.”

## **Family Involvement in Treatment Planning**

In summary, over half of the family members and care coordinators reported a fairly high level of family involvement in treatment planning. On the other hand, the involvement of extended family members in treatment planning was limited to only a few families, and absent in Ocean County. It should be noted that Ocean County only recently (2005) implemented its system of care. Across the entire sample, only half of the primary caregivers believed that the treatment plan was responsive to their families’ culture/ethnicity.

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## **Union County**

Six of the nine caregivers in Union County reported being involved in treatment planning for their child. One of these interviewees reported having extended family participate in the planning process, including the mother's boyfriend, her sisters and family friends. Two other parents reported that schools were involved in their planning process, including teachers, social workers, and a principal in one treatment plan, and a school social worker in another.

One primary caregiver reported that s/he was not involved in the planning process and does not know if the child was involved. Another caregiver did not recall a treatment plan, although services were delivered to the child and family. Two interviewees indicated frustration with the planning process. One said, "I understood what they were trying to do but the plan didn't work and my input was not accepted." Another commented that she felt that appropriate planning did not take place and that had to resort to filing a lawsuit to get a placement for her child.

When asked whether the treatment plan was culturally appropriate, three caregivers reported that the plan was responsive to the culture of their child and family. Two other family members responded that they did not feel that their plan was responsive to their culture, and two (2) DYFS guardians did not respond to this question.

All of the Union County care coordinators reported that families are involved in the planning of treatment. One care coordinator commented that she worked to identify family members who could be involved in planning, including a mother who was incarcerated (telephone contact), a grandmother who had significant health problems and an aunt who was not able to participate. Service providers in Union County reported that others frequently involved in planning included DYFS staff, juvenile justice staff, mentors, out-patient therapists, schools, and representatives from the developmental disabilities system.

## **Middlesex County**

Seven of the nine caregivers in Middlesex County reported being involved in treatment planning for their child. Three caregivers reported having members of their extended family involved in treatment planning. One caregiver reported that the treatment plan was done with DYFS and that they were not involved, and another stated that while s/he was involved with the planning, s/he was not satisfied with the plan and that "parents are left out" of the planning process.

Five of the nine caregivers indicated that the treatment plan was responsive to the culture of the child and family. Two caregivers responded that they did not feel that their plan is responsive to their culture, one because the child was not able to attend the family's church while he was in an out-of-home placement, and another due to having little contact or involvement with providers. Two caregivers "did not know" whether the plan was culturally appropriate.



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Six of the seven providers reported that families are involved in the planning of treatment. Of these, three said that plans are “family driven”. One care coordinator stated: “The family tells us their goals and we assist in meeting them.” One provider reported that the family refused to accept services. Service providers in Middlesex County reported that others who are sometimes involved in planning include parole officers, tutors, behavioral assistants and mentors.

## **Ocean County**

Three of the five families in Ocean County reported being involved in treatment planning for their child. Two of these children are living at home and one is in a residential treatment program where the family has been actively involved. Two caregivers stated that they were not involved in the planning process, and were not aware if their child is involved. For the three children who have DYFS guardians as primary caregivers, two guardians commented that the foster parent has input into the treatment plan. None of the primary caregivers in Ocean County reported having any members of their extended family involved in treatment planning.

Four primary caregivers (including one DYFS custodian) reported that the plan is responsive to the culture of the child. Two caregivers responded that they do not feel that their plan is responsive to their culture, and two DYFS guardians did not respond to this question.

Four providers reported that families are involved in the planning of treatment. One commented that the treatment plan is “done with the family. Nothing is done without family input.” Five providers reported that the treatment plans were done in residential treatment programs (3), hospitals (1) or that there is not a plan (1).

Service providers in Ocean County report that others involved in planning include:

- Child, guardian and cousin
- Foster parent, DYFS, child and probation
- Probation, FSO for 90 days
- “Everyone involved with the child, aunts, uncles, child”
- Mother, step-father, therapist, FSO, probation officer and child (when at home – while child is in RTP this does not apply)
- DYFS
- Therapist, school, parents and child
- Two did not respond to this question

In one Ocean County family, the care manager has never met the child. She reports that she administers Strength and Needs Assessments, but that there is not a plan in place for the child.

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## **Responsiveness of the Service Array to the Identified Needs of Children and Families**

This domain covers services and supports received by the child and family, unmet service and family support needs, child progress, and family experiences with the system of care.

### **Union County**

Primary caregivers and direct care coordinators in Union County reported the following services offered to the child and family: after-school programs, transportation, assistance with family's basic financial needs, mentors (for both child and parents), anger management programs, behavioral assistants, extended school year, therapeutic foster care, counseling (group and individual), medication management, tutoring, and residential treatment programs.

Caregivers and providers were also asked about unmet needs. Two primary caregivers in Union County expressed a need for transportation to services. One caregiver said that she "worries all day" because her child is alone while she works. Another caregiver noted the need for a Big Brother/Big Sister service, and another mentioned they a mentoring program for their child. Three families expressed a need for additional care coordination, two because their case was closed, and another who does not have an active care coordinator.

Unmet needs identified by providers include additional beds at Medicaid reimbursed treatment centers, increased coordination of services between DYFS and care coordinators, and pathways for smooth transitions from residential to foster care.

Caregivers and providers were asked a series of questions about the role of the Family Support Organization (FSO). Eight of the 9 caregivers in Union County reported that they had not received any information from the FSO. One primary caregiver said that she attended groups focused on adoption concerns and that she "found the group through word of mouth." Only one of the 8 providers said that she had given FSO information to the family, and had "no idea why they weren't using them".

### **Child Progress**

Seven primary caregivers reported that their child was making progress. The indicators of the progress include: "calmer; listens and respects authority; has less anger; is doing better at school; has fewer behavior problems; shows progress in behavior; and has better communication." Two primary caregivers did not report progress, one felt that services have "impeded his growth," and that "he has not gotten help from providers."

### **Family Experiences with the System of Care**

Six of the nine caregivers reported that they have found services to be effective in helping their family. Responses included: "things are much better; we're a closer family unit, things

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are good, I'm trying to be firmer with discipline, we're better able to handle problems with siblings. Four providers reported an increase in the family's ability to understand and work with their child. One care coordinator felt that the family needed additional support and stabilization, and another reported that the family is still "dysfunctional and unstable."

When asked whether the system inquired about family satisfaction, four primary caregivers reported receiving family satisfaction surveys, and another noted that she "may have received a survey in the mail." Three caregivers said that they did not receive surveys. Six care coordinators reported that caregivers are regularly given satisfaction surveys. The other two providers reported that they were unaware of family satisfaction measures.

## **Middlesex County**

The nine primary caregivers in Middlesex County reported that services received include:

- Family therapist and mentor
- Behavioral assistant, tutor, social worker
- Anger management program, mentor, psychiatrist
- Teaching assistant, medication management
- Group home, therapist, mentor
- In-home therapist, behavioral assistant
- Hospitalization, in-home therapy, behavioral assistant
- Mentor, family therapy
- None (caregiver refused)

Providers in Middlesex County added that individual counseling, karate, summer camp, transportation for the family to visit the child in a residential treatment program and assistance in a group home placement were services provided.

One primary caregiver reported an unmet need for substance abuse groups for youth. Other challenges in services that were reported by families include:

- A 45 minute drive to services
- Youth felt that he "wasn't heard" in planning services
- No flexibility in system

Three of the nine caregivers in Middlesex County reported that they received information on the Family Support Organization. Of these caregivers, one said that she had received a flier from the FSO, but could not attend meetings because of her work schedule. Another caregiver noted that she had limited contact early in care, but that she "Does not attend their groups." The third person who was interviewed as a caregiver was a young adult who has been involved with the youth group through the FSO. He reported that the group gave him an opportunity to meet other youth and to do volunteer work in the community. The other six caregivers reported that they did not receive information on the FSO.

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Three care coordinators in Middlesex County reported that the families in their care had some involvement with the FSO. One of these said that the FSO was unable to be effective for one family and only attended one treatment team meeting because of the FSO's lack of bi-lingual staff. Four care coordinators reported that the caregivers did not have information on the FSO.

## **Child Progress**

Seven caregivers reported that their children were making progress since they began receiving services. Six caregivers reported that the child shows academic improvement since receiving services. One caregiver talked about the child having better anger control, a job, and increased ability to pay attention. Two others reported that the child was progressing slowly. Two primary caregivers reported that the child has "not done well with services," or "he's doing good, but not due to services received – nothing was helpful at all."

Five care coordinators reported that the child has shown improvement since receiving services. One did not respond to this question due to lack of knowledge of progress since the case was recently transferred to her. Another family reportedly had refused services.

## **Family Experiences with the System of Care**

Three of the nine caregivers reported positive changes in their family since services were received. One says that "things are much better," another that the child was "doing fine." Four caregivers reported receiving family satisfaction surveys; the other five caregivers were not given surveys. Three of the seven providers reported that they send out family satisfaction surveys.

### **Ocean County**

Caregivers in Ocean County reported that their children received the following services:

- Residential treatment programs (2)
- Hospitalization (1)
- Substance abuse counseling (out-patient) (1)
- Outpatient therapy (1)
- Foster care (specialized – "medically needy") (1)
- Behavioral therapy (1)
- Family therapy (1)

For the three children who are in foster care, they are receiving therapy from a children's mental health provider, (2) medical care and consultation with a nurse in response to the child's pregnancy (other services are "on hold" until after the birth of her child), and (3) "behavioral therapy" weekly. The caregiver whose child is in the community reported that the child receives out-patient drug counseling three times a week, and that she meets with her care coordinator weekly. This parent also reported having a strong

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crisis plan where she can call her care coordinator and receive quick response from MRSS. She felt that the “last nine months has been great. Everyone is trying to keep our family together. Our goals are the same.”

Three caregivers, whose children were currently out-of-home, reported that few services were available to them. Two of the children were in residential treatment programs, and one was in a hospital, after spending five years in residential programs. Her mother felt that the two-month delay in getting community-based services in place added to the need for hospitalization. Reportedly, there is no discharge plan, and the caregiver felt that the care coordinator “is not interested in helping the family or in the outcome for child.” Another caregiver reported one visit from the care coordinator monthly; another “never sees” their care coordinator. The third parent also reported receiving only residential care for the child, with a care coordinator who is not engaged with the family.

Two providers in Ocean County reported that transportation and family support through the FSO were also offered to some of the families who were interviewed

When asked about unmet needs, one primary caregiver expressed a need for additional substance abuse services for young adults, and another expressed a need for camps and after-school programs to utilize when her child returns from residential care. One service provider expressed a need for programs for pregnant teens, and two reported a need for transportation for families.

In Ocean County, three of the 8 primary caregivers reported being referred to the FSO. Of these parents, one used the FSO when the child was still residing in the family home. This mother reported that the FSO responded with a CMO care coordinator to their home during a crisis. The FSO representative also attended planning meetings with the family. Another caregiver reported that the FSO came to their home, and went to court with them, and the third reported that she receives literature and newsletters from the FSO but has not attended meetings because of her work schedule. Two primary caregivers were not aware of the FSO’s and the other 3 caregivers were DYFS guardians.

Three providers in Ocean County reported that they referred the primary caregivers to the FSO. Of these, one said that the FSO offered a peer partner, but the family did not accept the service, and two said the family has a FSO peer partner. Another provider reported that the FSO “calls” families.

## **Child Progress**

Primary caregivers who were family members listed the following progress:

- “Very pleased with progress, the child has better grades, behavior, is 100% better. She stopped hurting herself, destructive behavior and running away.”
- “Ups and downs in rehab, but the child is happier lately.”
- Child’s self-esteem is better.

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- Satisfied with child's improvement in a residential treatment program
  - One family feels that the child is showing short-term improvement due to their placement in a residential treatment program.

Primary caregivers who are DYFS guardians report that the children are doing well in foster care, with one showing improved behavior; another is "trying to be good" while she waits for services to begin after she gives birth.

Three care coordinators felt that the child is improving in a residential treatment program. One reported that a child's school grades and behavior has improved; another believed that the child's communication has improved. Two reported that the child has resisted treatment which has limited their progress.

## **Family Experience with the System of Care**

Five primary caregivers reported that the family has had positive results from the child's services: "We can talk again, things have calmed down," and, "We're not as stressed". Providers indicated that six families were improving due to services provided to the child. These include a family where therapy is helping the mother to cope better; another where the mother is doing well with a job and stable housing; and a family that is managing well with increased structure and support. One care coordinator noted that the "mother is keeping the child on the right track. She is a great person and wants the best for her child."

Two primary caregivers reported that they received a satisfaction survey in the mail; the other six caregivers had not received requests for information on their satisfaction with services. Service providers responded that: "Families are given surveys at discharge from the facility, or that "that forms are given out by the quality assurance staff, or sent via e-mail or hand-delivery. One provider said that "Surveys are given out to certain families."

In summary, there appears to be a natural progression of a wider array of community-based services available to families in systems of care that have been established for longer periods of time across counties. The "older" sites had more children maintained in the community, with a wider array of services than the newly established system of care that report fewer services available and a higher rate of out-of-home care.

Family satisfaction with the system of care is tied to the supportiveness and availability of a care coordinator who can guide the family and provide quick response to them. Comments from primary caregivers who report progress for their child and family responded with comments like, "my 'care coordinator' is my backbone. She goes to the school with me," or "I called my 'care coordinator' three or four times a week. My child is crazy about her." Another responded, "They listen, understand everything, and give positive feedback." "They assist with programs and resolutions."

Negative comments from primary caregivers regarding services include, "The care coordinator is not interested in helping my family;" "There is little or no contact with providers," and, "There is a lack of communication between providers."

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## Overall Strengths

There are examples of positive outcomes for children and families who are engaged in multiple systems. One is a caregiver who attributed the recent achievements of her child to the level of care coordination, “Until nine months ago, experience with the state of NJ was a nightmare. There was no support and no one to call. They wanted to ‘put her (child) away’. She was sent to doctors who only spent five minutes with her. Now, it is fantastic.” This parent feels that the child’s grades are improving, her destructive behavior has ceased, and she is well-behaved in school. The parent can call the in-home therapist in crisis, and the response time (with a home visit) is less than 45 minutes.

## Overall Challenges

Regarding goal of returning children from residential treatment programs to community-based care, there seems to be a lack of linkage in provision of communication tools and support to families in maintaining contact with children who are in out-of-home placements. Across the three counties, care coordinators who have children in residential treatment programs appear to have limited contact with the child and family.

A need for transition services for all levels of transition – including from residential treatment settings to foster care, returning to the community after an out-of-home placement and returning from DJJ facilities back to their home, are noted as needed by both providers and caregivers. In addition, transition to adult services was noted as an unmet need by several respondents.

Regarding the involvement of Family Support Organizations, only seven caregivers across the three counties reported that they had even received information about the FSO. This disappointing finding may be related to poor communication, the limited capacity of FSOs, as well as the length of time that FSOs are involved with families. Nevertheless, the goal should be that FSOs are notified about all families with a child with multi-system involvement and then offer aggressive outreach and support services to these families.

One of the major challenges that impede family involvement is the infrequency of notification to all partners involved in the child and family team planning. According to guidelines once a child is approved for services through the CSA, all inter-agency partners are supposed to be notified. However, the perception is that receipt of notification often is not experienced by all involved partners. Consequently, the FSO may miss the initial child and family team meeting resulting in lack of family support. Therefore, the strength and needs assessment and crisis planning does not always involve the FSO. The lack of interaction in the early stages of assessment reduces the array of services the child and family can benefit from during the 90 day timeframe.

Lack of trust is evident as it relates to sharing child and family information with all partners. Access to the strength and needs assessment is not always provided and needs to be accessible in order to have a clear understanding of challenges and problems faced by the child and family. During the FSO focus group numerous directors voiced that no hesitancy



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should be present for sharing information, since the FSO is listed on the family release form, and the Care Management Organization is responsible for distributing all necessary information to all partners.

## Recommendations

The findings from the Child and Family Reviews lead to the following recommendations:

- Involve and engage caregivers in a better understanding of the role of New Jersey's assessment process in service planning.
- Present caregivers and other family members with information and choices about the full array of services and supports that are available in their community.
- Notify Family Support Organizations about new children and families that are entering the system of care.
- Hold FSOs accountable regarding their role in outreach to and engagement with caregivers and youth.
- Strengthen linkages and communication tools so that both primary caregivers and case managers maintain contact with youth and the treatment planning process during out-of-home placements.
- Provide caregivers and youth the services and supports needed during times of transition from residential and inpatient programs to lower levels of care.

Regarding the goal of active family engagement in assessment and treatment planning for their child and family, the following case vignette from the Child and Family Reviews illustrates what can and should be happening for every child and family.

One example of services to a child and family in a mature system of care site follows. The child entered the Care Management Organization (CMO) through their involvement with DYFS. The child was experiencing disruption in both his school and home settings due to mental health related behavior problems. When the CMO became involved with the family, a child and family team was formed that included the youth, his mother, his sisters, the boyfriend of his mother, his step-grandfather, friends, and his school teacher and school social worker. A treatment plan was designed that recognized the culture of the family. The family reports that, "access to the case manager" was the most effective part of their success. Services that were put into place for the child and family focused on child health and safety (the child had a history of behavior-related injuries). They included an in-home therapist; medication monitoring; a psychiatrist; a visiting nurse who focused on safety and nutrition; assistance in money management; and resolving Medicaid issues.

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The school counselor and teacher were involved in the child and family team meetings that were held every 75 days. In addition, the DYFS worker attended at least 75% of the meetings. One successful goal of academic achievement included having the child move from a mainstream classroom with 30 students into a smaller class for two classes a day. The child responded well to the individualized support in the smaller classroom. He self-reports that school is “great” and that the assistance of his teachers was instrumental in his remaining in school.

The family goal of working on their interpersonal relationships was addressed through family counseling. That goal was achieved. In addition, the child and family were engaged as a group through the CMO. The mother became stronger in her ability to set limits, to participate actively in the schools that her three children attended, and to be financially independent. Their arguing decreased, and the child’s safety increased. When his case was closed, the child had decreased his unsafe behaviors, was experiencing success in school, and the family reports that they were functioning well.

The case had been closed for a year prior to the family interview. During that time, the family maintained their achievement, the child had received a work permit and was successful engaged in summer employment, and was looking forward to beginning high school in the fall of 2006. ■

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# Chapter 8: Sizing the System

## Research Question:

- **Is the system appropriately sized in relation to prevalence estimates data, geographic equity in distribution of services and resources, and sizing estimates methodologies used by other states?**

## Introduction/Background

In 2000, DMA Health Strategies (then known as Dougherty Management Associates, Inc.) analyzed New Jersey's provision of children's mental health services across its counties in preparation for planning systems of care. The major finding was that New Jersey expenditure rates for mental health services were poorly matched with indicators of need on a county by county basis. New Jersey requested that we update this study to determine whether New Jersey now better meets the needs of its children. In addition, we will examine how implementation of systems of care has changed New Jersey's relative use of different levels of care (specifically, inpatient, residential and outpatient and other community services). Given the phased implementation of systems of care, we have a natural experiment that is likely to provide indications of the impact of this program and the degree to which changes are consistent with the principles of systems of care. Finally, we will compare New Jersey's provision of behavioral health care to other demographically similar regions as well as other regions that have implemented systems of care. These analyses should provide some perspective on how far New Jersey has moved toward caring for children in the community, how New Jersey is using its resources to support children's behavioral health services and the degree to which there is room for changes in the allocation of resources between levels of care. On this basis, we will make recommendations about priorities for further developing New Jersey's children's mental health system. We are not, however, prepared to make recommendations on the proper size of the New Jersey service system. First, our sources of data have some significant limitations. Second, our prior comparisons of children's mental health service provision finds so much variation between states that no researcher has ventured to identify what levels of penetration, utilization and expenditure are appropriate to meet the needs of children with mental health conditions.

## Methodology

### Data

#### **2004 and 2005 Data Sources.**

The Division of Children's Behavioral Health Services (DCBHS) was created during fiscal year 2001, and until recently was a constituent agency of New Jersey's Department of

Human Services. In its first year, DCBHS pooled approximately \$167 million across child welfare, juvenile justice, and mental health, by restructuring the publicly funded systems that serve troubled children. New funds of \$39 million were included in DCBHS in its first year and over \$100 million were added over the following four years. In addition, Medicaid covered services were expanded by conversion from the Medicaid Clinic to the Rehabilitation Services Option. The New Jersey Initiative created a single payer system by lodging all Initiative dollars (Medicaid and non Medicaid) with the State Medicaid agency and having the Medicaid agency handle all reimbursements through its existing financial management system. Paid providers in New Jersey are on a fee-for-service basis through a combination of cost reimbursable and fixed price arrangements.

We sought comprehensive utilization and expenditure data from all children's mental health funding sources, sorted to eliminate children counted in more than one data collection category. New Jersey's consolidation of billing for both Medicaid and non-Medicaid services facilitated this process. We received data from the Medicaid system for calendar years 2004 and 2005 for all specialty mental health services. This included both Medicaid services that receive federal match and non-Medicaid services funded by other children's agencies and paid through the Medicaid claims payer. However, the transition from DCBHS, Child Welfare and Juvenile Justice contract funding methods to payments through Medicaid's billing system was phased in as the counties implemented systems of care. This means that data received from the Medicaid payment system include non-Medicaid services for the phase 1 and 2 counties that had implemented systems of care, but not for the phase 3 counties yet to do so, as shown in **Table 14**.

<b>Table 14.</b>					
<b>Counties Included in Consolidated Data by Year</b>					
<b>Phase</b>	<b>Start Date</b>	<b>Date Began Medicaid Billing</b>	<b>2004 Data</b>	<b>2005 Data</b>	<b>County</b>
1	January 2001	September 2001	Full Year	Full Year	Burlington
1	January 2001	September 2001	Full Year	Full Year	Monmouth
1	January 2001	September 2001	Full Year	Full Year	Union
1	January 2002	September 2002	Full Year	Full Year	Atlantic/Cape May
1	January 2002	September 2002	Full Year	Full Year	Bergen
1	January 2002	September 2002	Full Year	Full Year	Mercer

<b>Table 14.</b> Continued <b>Counties Included in Consolidated Data by Year</b>					
<b>Phase</b>	<b>Start Date</b>	<b>Date Began Medicaid Billing</b>	<b>2004 Data</b>	<b>2005 Data</b>	<b>County</b>
2	July 2003	March 2004	Partial Year	Full Year	Hudson
2	November 2003	July 2004	Partial Year	Full Year	Middlesex
2	February 2004	October 2004	Partial Year	Full Year	Essex
2	February 2004	October 2004	Partial Year	Full Year	Camden
3	January 2005	September 2005	Not included	Partial Year	Passaic
3	July 2005	March 2006	Not included	Not included	Ocean
3	July 2005	March 2006	Not included	Not included	Gloucester/Salem/Cumberland
3	January 2006	September 2006	Not included	Not included	Sussex/Morris
3	January 2006	September 2006	Not included	Not included	Hunterdon/Somerset/Warren

<b>Table 15.</b> <b>Request for Consolidated Data from New Jersey Medicaid</b>	
<b>Service</b>	<b>Provider type</b>
<b>Inpatient Hospital</b>	Inpatient Mental Hospital
	Acute care general hospital
	Other hospital
<b>Residential</b>	
Residential Treatment Centers — specialty and non-specialty	Residential treatment Centers
Non-JCAHO residential — specialty and non-specialty	CSOCI (Children's System of care Initiative)

<b>Table 15.</b> Continued <b>Request for Consolidated Data from New Jersey Medicaid</b>	
<b>Service</b>	<b>Provider type</b>
Group Homes	CSOCI (Children's System of care Initiative)
Treatment Homes	Home Health
Crisis Beds	CSOCI (Children's System of care Initiative)
<b>Community/Outpatient</b>	
Partial Hospital	Hospital
Medicaid Outpatient	Mental Health Clinic
	Nurse practitioner – MH
	Psychologist
	Physician – psychiatrist
	FQHC
	Hospital Outpatient Department
	Any MH services in Outpatient
	Any MH services in Community health clinic
MRSS	CSOCI (Children's System of care Initiative)
CMO	Targeted case management
YCM	CSOCI (Children's System of care Initiative)
BIAAC IICB	CSOCI (Children's System of care Initiative)
Behavioral Assistance	CSOCI (Children's System of care Initiative)
Pharmacy	Major Classes of Atypical Antipsychotics

**Table 15** lists the service types for which data was requested, and shows how they are categorized into inpatient, residential, outpatient/community, and pharmacy. The ASO services provided by the CSA, funding for FSOs, and certain funding for the CAYAC functions that did not involve direct service provision were considered administrative expenses and excluded. In the analysis that follows, data received from this request is referred to as 'Consolidated New Jersey Mental Health Services', since it does not represent a total of the mental health service system, just that part whose payments go through the Medicaid payment vendor.

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Most children in the database are assigned to counties based on the county where they registered for Medicaid or qualified for non-Medicaid system of care services. However, a certain percentage of children are not identified with any county. They are rather identified as being enrolled for system of care services (that is, children who qualify for certain system of care services, but are not Medicaid eligible), are being served in an out of state facility, or are eligible for Medicaid as an individual. Children falling into these groups account for 9% of Medicaid enrolled children under 18 and for 6% of their expenditures. They account for most of the non-Medicaid children receiving services in the consolidated system, 89%, and 28% of expenditures. Should those children be assigned to the county they live in, there is a possibility that some of our conclusions about counties could change. However, that would only tend to happen if only a few counties accounted for most unassigned children. We have excluded these children and the costs of their services from our county charts, but they are included in state totals and averages.

Some of our analysis will group counties based on their degree of maturity in implementing systems of care, to see if there is any effect from this effort, assigning them to the phases as indicated in **Table 14**.

In addition, we used data produced by New Jersey's CSA on the children it serves, those served in system of care programs, and those receiving Youth Case Management Services. This data was a snapshot of the caseload on June 25, 2005. Finally, we present a summary of DCBHS' service budget for FY2005. This was its first dedicated budget as a department.

### **Data from Prior Study**

DMA's original study used data from Medicaid, DYFS and DMHS, adding them together to generate an indication of the resources available to fund the children's system of care. Data from the Medicaid PRO are from 1998 claims and eligibility files. DYFS residential expenditures are from FY2000. DYFS reported expenditures according to district office of supervision by zip code. In most cases, these districts correspond to counties or cities; however, those costs that do not correspond are categorized into an 'other' category that accounts for roughly 5% of the expenditures; an amount that does not materially affect the findings. DMHS was not able to be allocated to counties based upon available data. Therefore, the totals exclude \$5.4M in DMHS residential expenditures, net of other revenues including Medicaid. This data set also categorizes inpatient, outpatient, residential and psychotropic services and expenditures as indicated in **Table 15**, though the services added with the implementation of systems of care are new since the original study. Appendix G includes a table describing our data sources in more detail.

### **Demographic and Need Data**

To better make comparisons between counties and states, we have taken into account their child population, and particularly their population of poor children, since they are most likely to lack private insurance and rely upon the public children's mental health



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system. In addition to Census estimates for population and poverty, this analysis draws on several additional need indicators. The rate of substantiated child abuse referrals, the rate of out of home placements reported by the child welfare agency, and the rate of juvenile arrests are collected by Kids Count: New Jersey on a county by county basis. Census data used in the original sizing study were estimates of July 1999, and those for this update are estimates for 2005. For both the original and this analysis, the latest available poverty estimate was applied to the population estimate for the analysis year. While the years vary, we do not believe it is very likely that the different years will have a significant effect on the comparative county expenditure levels.

## Methods

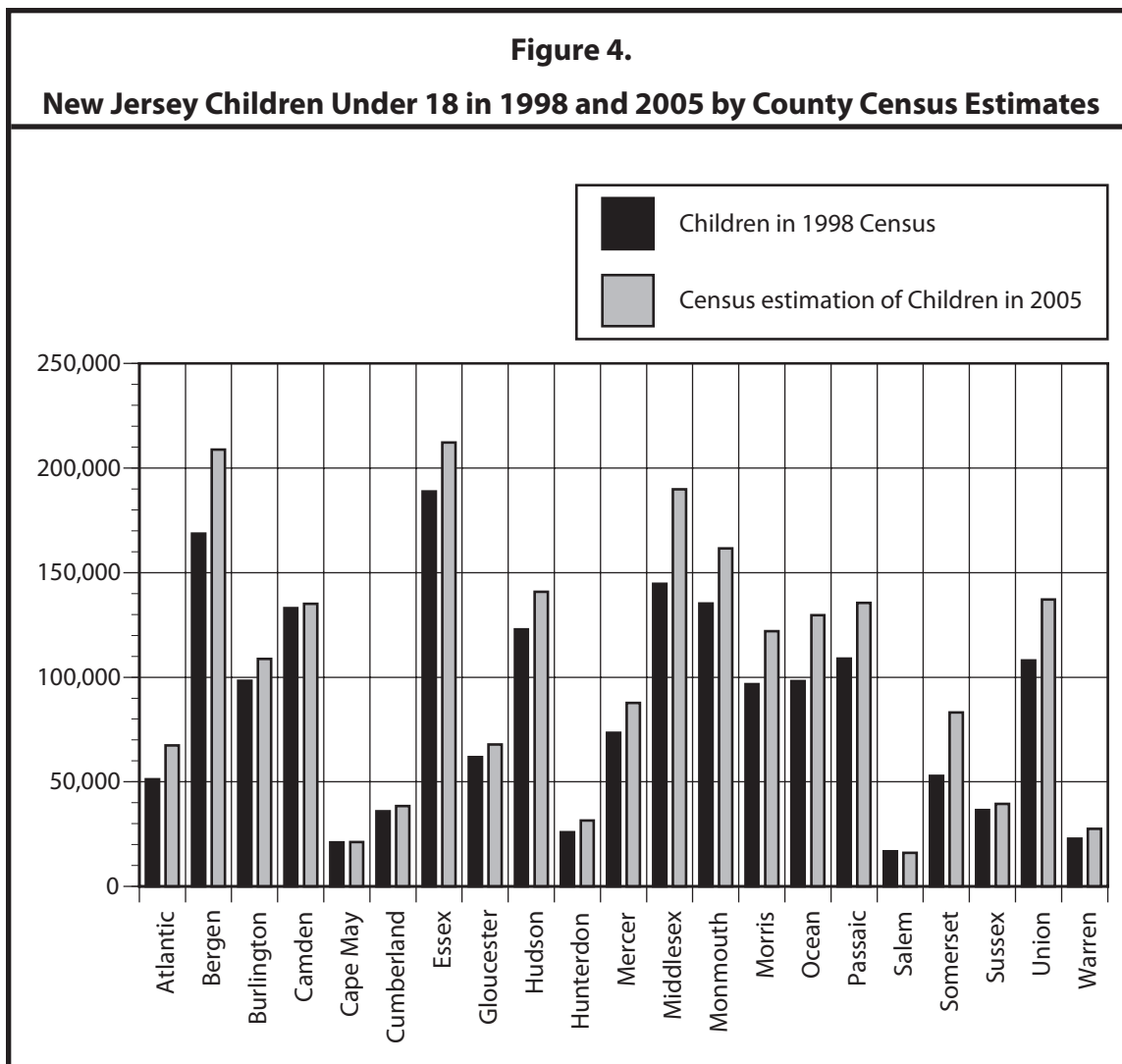
New Jersey consolidated data for 2004 and 2005 was stratified to allow us to separately analyze children and youth (ages 0 to 17) and young adults (ages 20 and 21). The age range excludes young adults aged 21 and 22, who are served in the system of care. The data were also stratified into AFDC and SCHIP Plan A (income eligible) enrollment categories, DYFS (child welfare) eligible individuals, and SSI (disabled) eligible individuals. Children who were not Medicaid eligible were also tabulated. Data were further sorted by the child's county of origin. Data on children served, Medicaid expenditures and non-Medicaid expenditures were also stratified. While children served were unduplicated within each cell, they were not unduplicated in the totals. Eligibility, age and county categories should be unique, but there will be some duplication of children served in one or more levels of care. This will tend to over count the children served by New Jersey.

**Other States** — We also sought public data or requested relevant data from states and groups of counties that could be usefully compared to New Jersey. We have noted in charts any characteristics of the data or methodology of calculation likely to be material to the interpretation of the chart. A table in Appendix G is a complete list of the data specifications and limitations. In general, we simply added Medicaid enrolled children receiving services to non-Medicaid children receiving services. Since it is common for a child to gain and lose Medicaid eligibility within a year and thus receive Medicaid and non-Medicaid services, this method would count that child twice. Massachusetts and Maryland gave us estimates of the likely overlap that allowed us to reduce our total counts to account for the degree of duplication they generally experience. Our discussion will indicate that there are significant differences between children's service systems and the ways they count services that make such comparisons far from clean or exact. However, the comparisons do provide a starting place for understanding a state's style of service provision and options for moving in other directions.

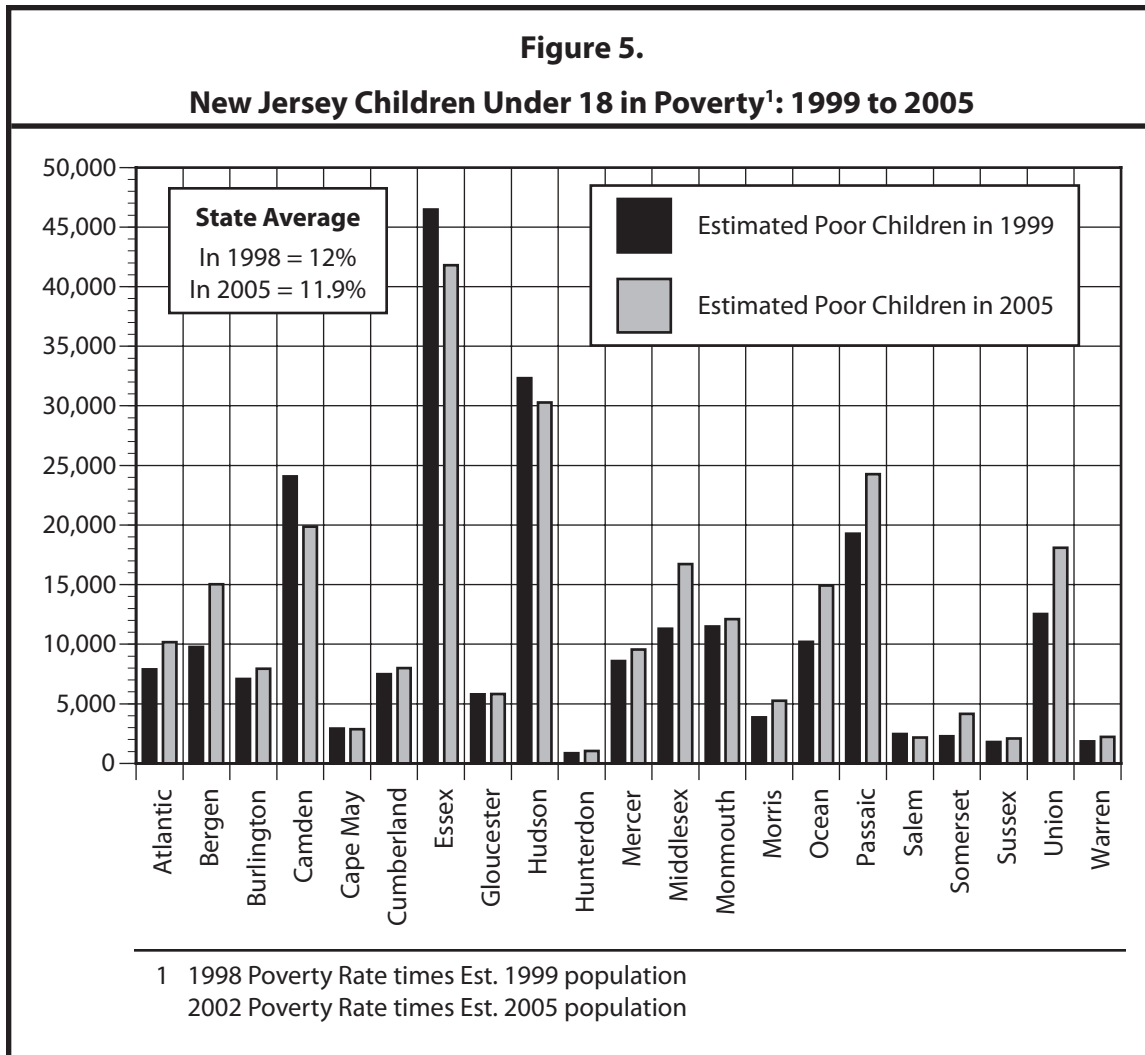
## Changes in County Demographics and Need

This section provides an overview of changes in New Jersey's demographic and need characteristics between the time of our original study and 2005. Over this period, the number of poor children actually dropped in most years, but began to increase in 2002 and jumped

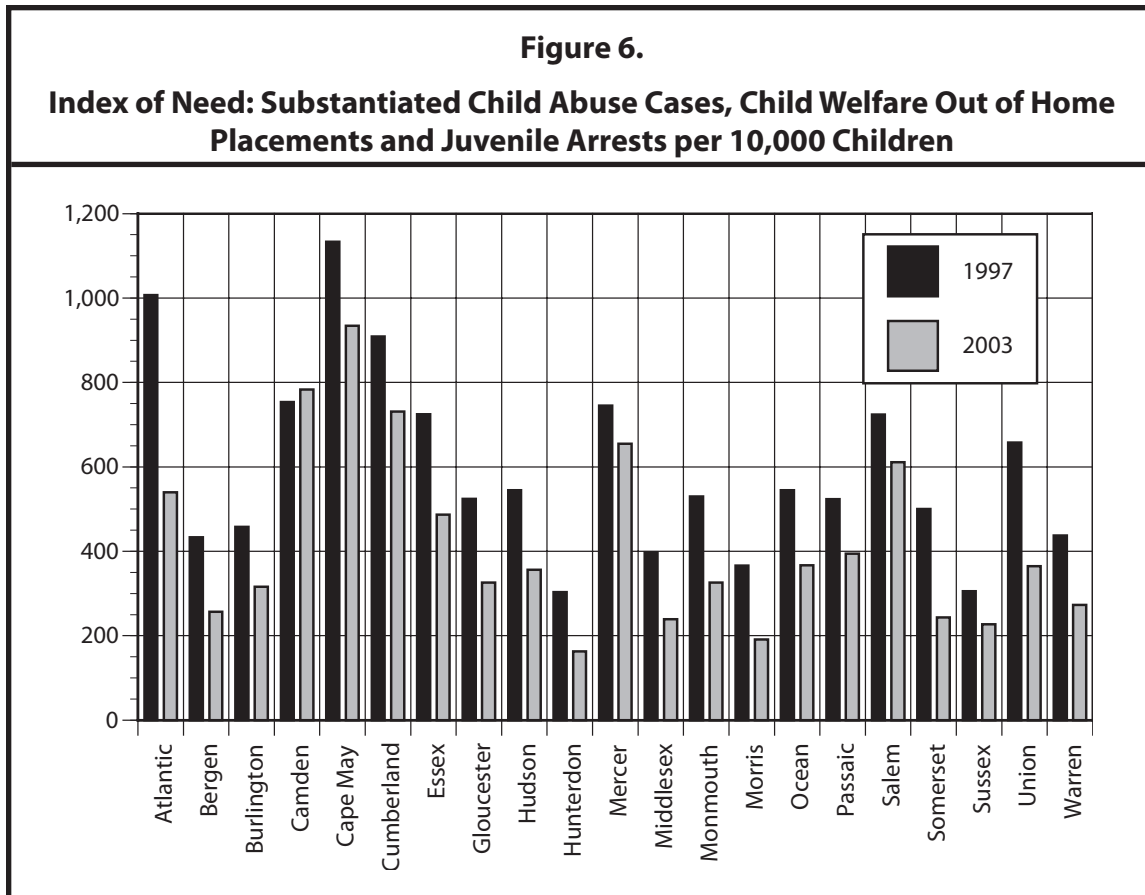
by 15% between 2002 and 2003, the most recent year the Census Bureau has estimated. The population of children under 18 grew at a statewide average of 20% between 1998 and 2005, while some counties experienced much higher rates, with Somerset County experiencing the fastest growth rate of 57%. A few counties had very low rates of growth or actually decreased, as did Salem, which actually lost 4% of its children.



Though the poverty rate in New Jersey decreased from 12.6% to 11.9% over this period, the number of children in poverty grew by 10%, about half as fast as the population of all children. Counties' poverty rates remained fairly stable, rarely changing by more than one percentage point. However, given the growth in the overall child population in some counties, a constant rate of poverty increased the numbers of poor children dramatically.

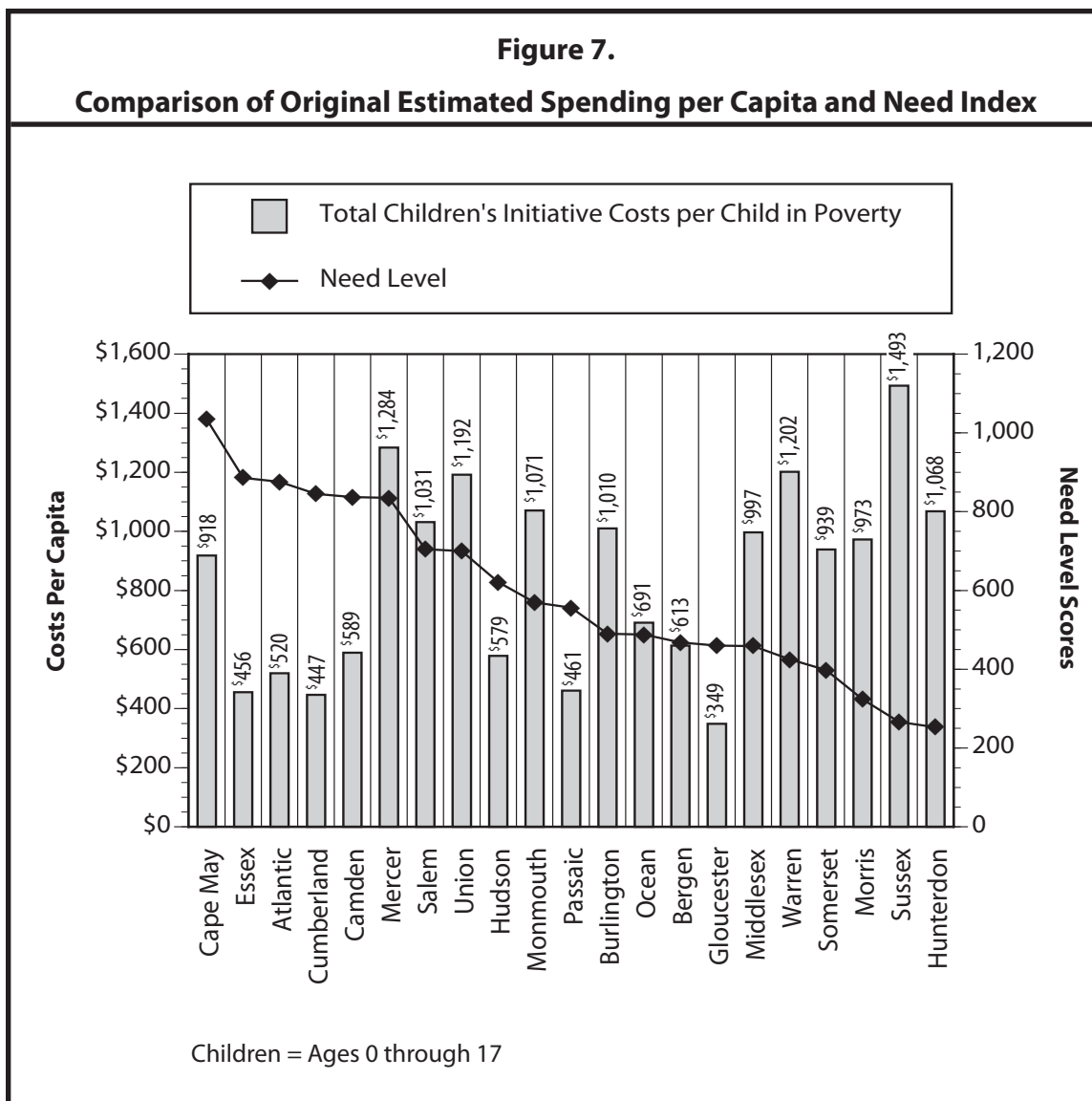


The following chart looks at changes in the need index we constructed by adding together the three KidsCount measures specified above, and dividing it per ten thousand children. This provides an indication of the relative numbers of 3 groups of children at high risk of mental health problems. **Figure 6** shows that this index fell statewide. Though out of home placements increased, the number of substantiated cases of child abuse and the number of juvenile arrests fell. Together with an increase in the total child population, this resulted in most counties showing decreases in this index. This particular index tends to be driven by the number of juvenile arrests, which are much more numerous than substantiated child abuse cases or children in out of home care. Overall, this need index decreased by 30%, and we saw relatively little difference between the weighted averages of the counties in the three implementation phases, suggesting that each phase had similar rates of need over the participating counties.

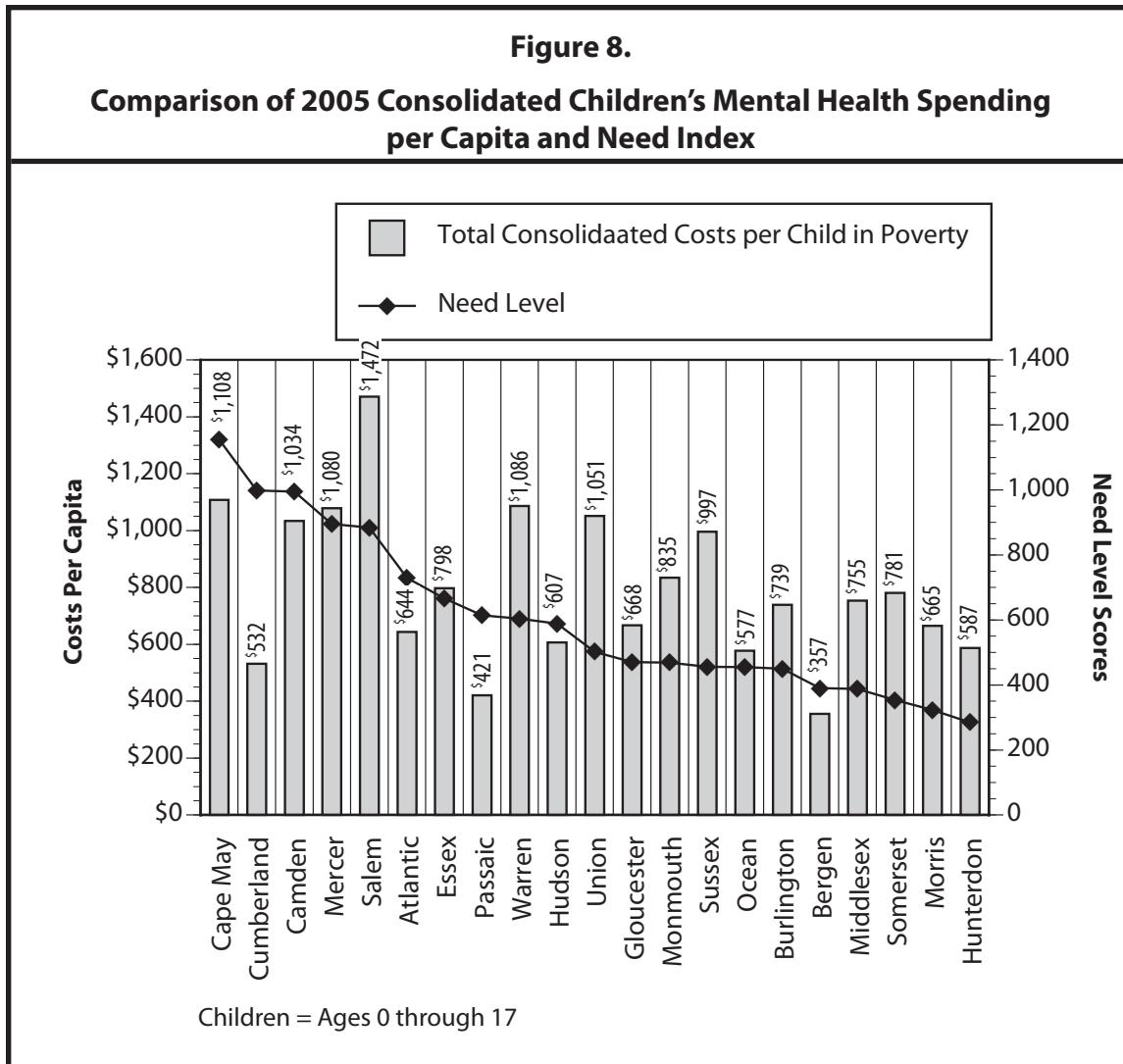


## Children's Mental Health Expenditures Compared to Need

For the original sizing study, we added together New Jersey's Medicaid expenditures, DMHS expenditures and DYFS residential expenditures to get a total of \$174.8M on expenditures for children's mental health services. The following figure highlights the primary conclusion of our earlier sizing study, the gap between expenditure rates and indications of relative need. This figure compares expenditures per child in poverty to the need index. At the time of the original study, few counties with the highest level of need had the highest rate of expenditures, while a number of the lowest need counties were among those with the highest rates of expenditure.



Medicaid expenditures increased by 86% from the earlier period to 2005. Between the two data sets, Medicaid and non-Medicaid statewide expenditure per child in poverty increased from \$695 to \$854. This increase understates the total increase in funding for children's mental health because the 2005 figures do not include non-Medicaid expenditures paid outside of the consolidated system. **Figure 8** compares 2005 consolidated expenditures per child in poverty to the same index. It shows that New Jersey has made considerable progress in matching expenditures to the level of need. Considerable variation remains, and the range is similar to the range found in the original study, but the standard deviation decreased by about 10%, indicating that more counties are closer to the mean. More importantly, counties with higher need are now more likely to have the higher levels of expenditures, while those with lower need are unlikely to exceed the state average. However, a few counties, Cumberland, Passaic and Bergen, stand out as having very low rates, and two of them have relatively high need, indicating that there is more room for progress.

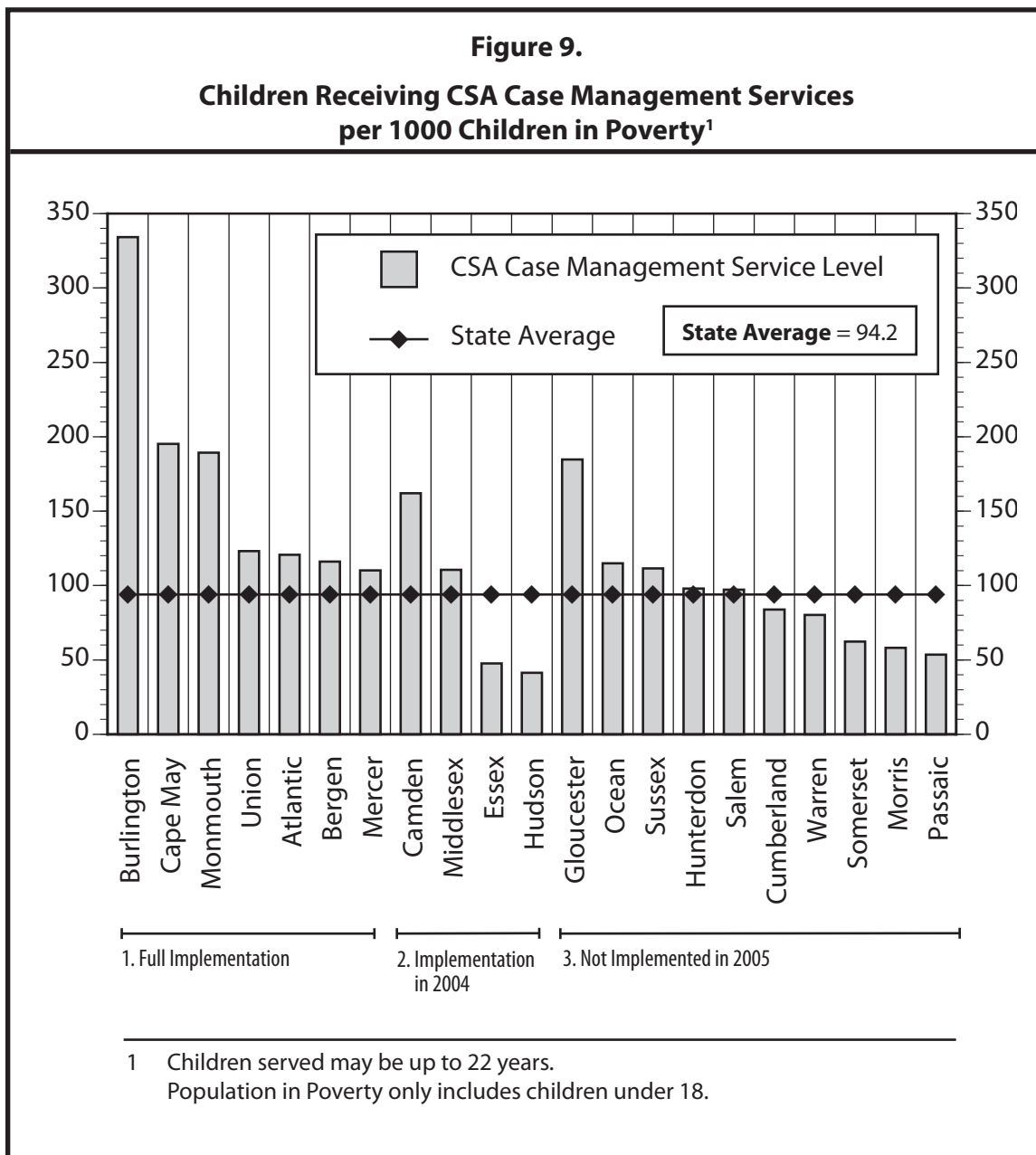


## Provision of System of Care Services

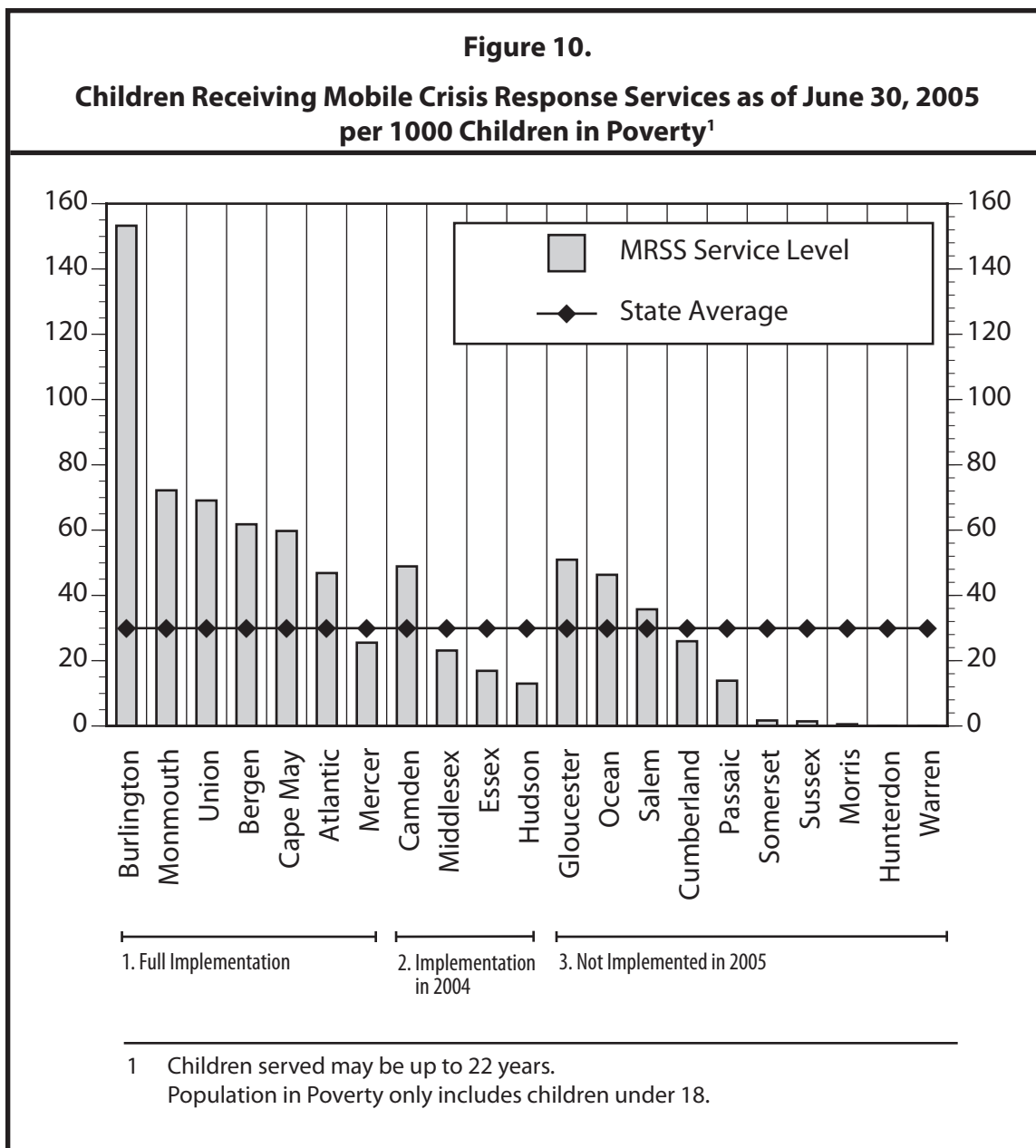
This section focuses on the services introduced as part of New Jersey's implementation of systems of care, and the closely related service of Youth Case Management. Our focus is on the distribution of services by county, taking into account their phase of implementation. We analyzed a snapshot of children with active cases on June 30, 2005 from a report produced by the CSA.

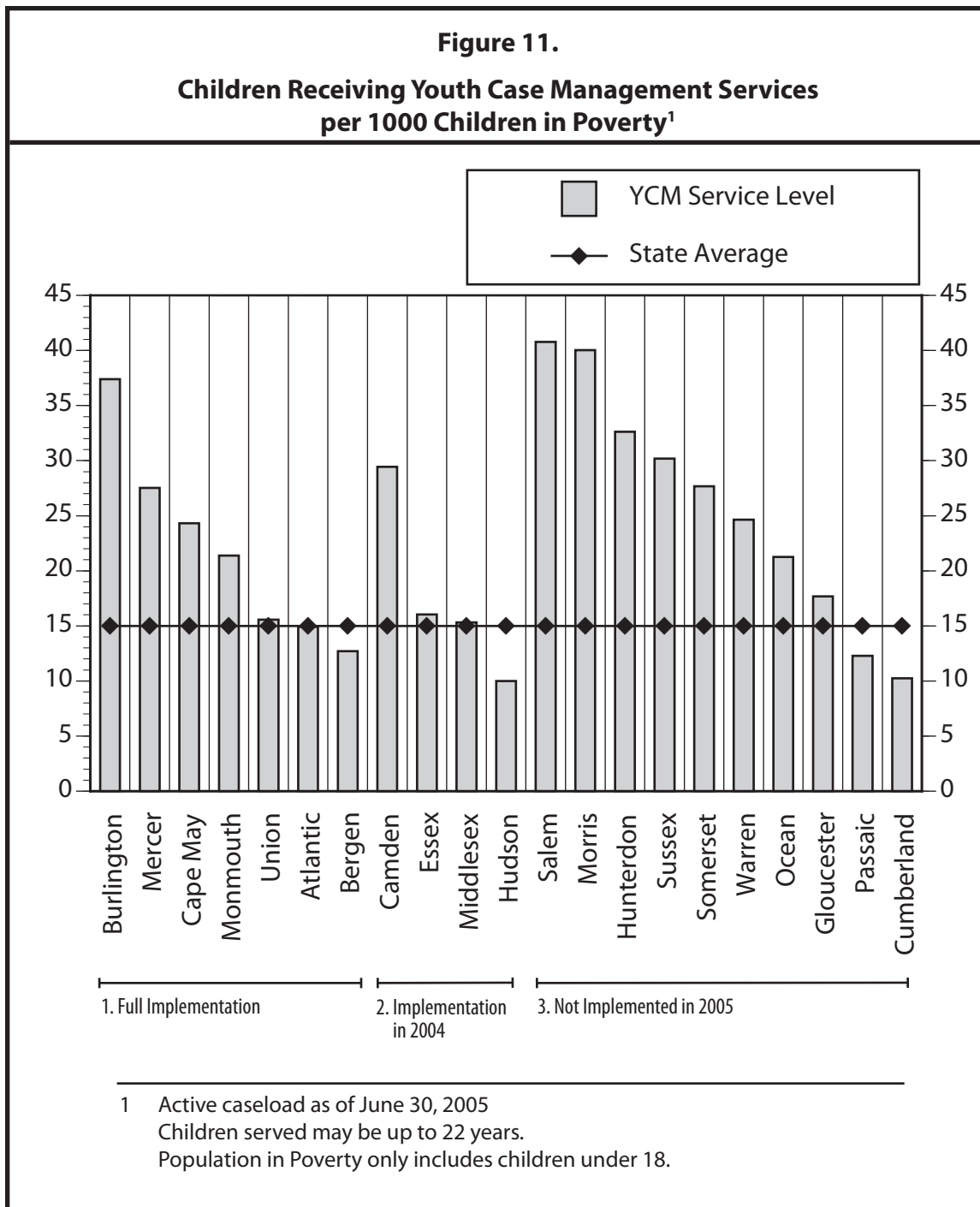
Most children receiving public mental health services in New Jersey access case management from the CSA at some level. **Figure 9** shows that provision of CSA case management tends to be higher in the counties that have more fully implemented systems of care, though Essex and Hudson counties in phase 2 are well below average and some phase 3 counties are above average. Mobile crisis services, however, are introduced as systems of care are implemented, and therefore were not provided in all counties during 2005. Not

surprisingly, the number of children served by county is closely related to implementation phase. Burlington County, one of the two earliest implementers, is a notable outlier for both service types, serving almost double the children as counties with the next highest rates.









In contrast, youth case management appears to be used most in counties where systems of care were not yet fully implemented. This is consistent with the absence of CMOs to carry some of the higher intensity and more complex cases in Phase 3 counties.

CMO and FSO services are designed to meet the needs of children and families with the more serious and complex cases, and should be considered in comparison to the population of children with serious emotional disturbance to analyze how well these services are

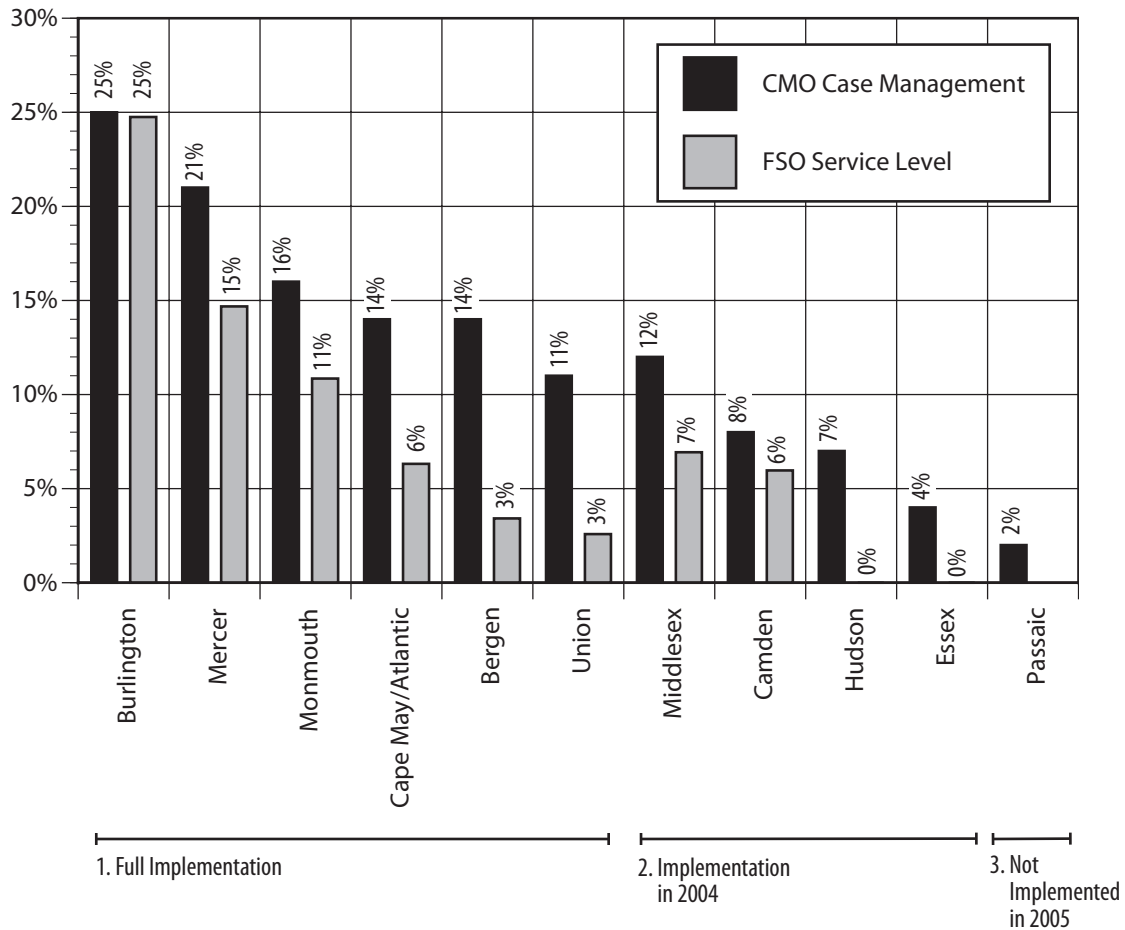
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meeting need. To estimate the number of children with SED in the county, we applied a 9% prevalence rate found for 9 to 17 year olds (Freidman et al. 1996) to the Census estimate of county population between the ages of 10 and 17. Because our numerator of children served may include children older and younger than this denominator, our method will overstate the degree to which systems of care were meeting the needs of children with SED, but this method will provide a reasonable basis for comparing the counties to each other.

**Figure 12** shows that Burlington County's CMO served the greatest proportion of estimated children with SED, approximately a quarter. Passaic County, a county only beginning to implement systems of care, served only 2% in its first few months. There is a clear pattern suggesting that systems of care with a longer history reach more children. With the exception of Burlington County, FSOs tend to serve fewer children than CMOs, though it is important to remember that the CMO count is the active caseload and the FSO count is the average for the quarter.

**Figure 12.**

**Percent of Estimated Children with SED Receiving  
CMO Case Management and FSO Services<sup>1</sup>**



- 1 CSO is the active cases on June 30, 2005.  
FSO is the quarterly average caseload.  
Children served may be up to 22 years.  
Population used to estimate children with SED includes children ages 10 through 17.

## Provision of Children's Behavioral Health Services in New Jersey, 2004-2006

This section analyzes provision of care in the full public behavioral health system, primarily funded by Medicaid. We evaluate whether systems of care has influenced patterns of care in this broader system. This analysis is based primarily on 2004 and 2005 Medicaid and non-Medicaid services paid through the consolidated Medicaid billing system. As stated earlier, this excludes certain DCF and DCBHS expenditures in the counties that had not yet implemented systems of care. These data include 0 to 17 year olds, which we refer to as children or youth, and 18 to 20 year olds, which we refer to as young adults. These data therefore exclude the 21 and 22 year olds that may be receiving system of care services.

**Table 16** shows that the number of children receiving mental health services increased 6% between 2004 and 2005, with those under 17 increasing at a rate of 7% and those 18 to 20 at a lower rate of 3%. The pattern of service use shows that one of the desired goals of systems of care, decreasing out of home treatment in inpatient and residential settings, is in process. Five percent fewer children received inpatient care and nine percent fewer received residential care in 2005 than in the prior year. There was a dramatic decrease (25%) in young adults' use of residential services. Provision of outpatient and community services also increased by 8%. While the changes in patterns of care are clearly desirable, and the rate of increase in the number of children served is significant, it is not clear that it is sufficient to keep up with growing need. While the Census estimated little growth in the child population between 2004 and 2005, the most recent available estimate of children in poverty showed growth of 15% between 2002 and 2003. If the number of children in poverty has continued to grow faster than the overall child population, then service growth may not be sufficient to keep up.

<b>Table 16.</b> <b>New Jersey Consolidated Mental Health Services for Children:</b> <b>Children Receiving Mental Health Services By Year and Level of Care</b>									
	2004			2005			Percent Change		
	0-17	18-20	Total	0-17	18-20	Total	0-17	18-20	Total
Inpatient	1,970	492	2,462	1,878	454	2,332	-5%	-8%	-5%
Residential	895	124	1,019	830	93	923	-7%	-25%	-9%
Outpatient/ Community	28,794	3,270	32,064	31,133	3,450	34,583	8%	6%	8%
<b>Duplicated Total</b>	<b>31,659</b>	<b>3,886</b>	<b>35,545</b>	<b>33,841</b>	<b>3,997</b>	<b>37,838</b>	<b>7%</b>	<b>3%</b>	<b>6%</b>

Another standard for considering whether children's mental health needs are being met well is to calculate what percentage of children with mental health problems are receiving services. We used prevalence rates to estimate the number of New Jersey children with a

mental health or substance abuse diagnosis that causes minimal, significant, or extreme functional impairment. We found that New Jersey appears to be meeting a relatively small percentage of the need for mental health services. At best, it reaches the equivalent of 12% of children and young adults with minimum needs, and its more intensive services reach only 3% of the estimated number of children with significant or extreme functional impairments arising from their mental health condition.

<b>Table 17.</b>				
<b>Access to Mental Health Treatment for Children and Young Adults by Level of Need</b>				
<b>Service and Age Group</b>		<b>MH or SA diagnosis with Functional Impairment+</b>	<b>Estimated NJ Children with specified level of Need</b>	<b>Percent of Children in Need that Received indicated Services</b>
<b>Services</b>	<b>Number of Children Served in 2005</b>			
Consolidated MH Services — Age 0–17	31,659	Minimum	234,935	13%
Consolidated MH Services — Age 18–20	3,886	Minimum	71,047	5%
Consolidated MH Services — Duplicated Total	35,545	Minimum	305,982	12%
CSA Services	29,741	Minimum	351,566*	12%
YCM Services	4,694	Significant	184,154*	4%
CMO Services	1,792	Extreme	83,706*	3%
+ Source of Prevalence Estimate: Methodology for Epidemiology of Mental Disorders in Children and Adolescents (MECA Study) noted in The Surgeon General's Report on Mental Health (1999)				
*Because systems of care were not fully implemented, we adjusted the denominator of the CSA, YCM and CMO measures to account for only the counties in Phases 1 and 2.				

## Medicaid

Most children in New Jersey's public mental health system are served in by Medicaid, and become eligible for that system on the basis of low family income (AFDC and SCHIP Plan A), coming into the custody of the state (DCF) or on the basis of disability (SSI). Among children, a significant proportion of disabilities are mental health related, and many children with other disabilities have a mental health need. Children in state custody also have elevated rates of need for mental health services due to their experiences of abuse and neglect. **Table 18** shows New Jersey's Medicaid enrollment in 2004 and 2005 by eligibility category. Enrollment has been growing at an overall rate of 5%, with most

eligibility categories growing between 4% and 7%. Eighteen to twenty year olds who are in the custody of the Department of Children and Families and those enrolled in the SCHIP A plan, however, grew much faster. There has been little growth in the number of children with disabilities (SSI). These are significant growth rates, but these rates may not be keeping up with the growth of children in poverty.

<b>Table 18.</b>									
<b>New Jersey Medicaid Unduplicated Enrollment by Eligibility Category</b>									
<b>Eligibility Category</b>	<b>2004</b>			<b>2005</b>			<b>Percentage Change</b>		
	<b>0-17</b>	<b>18-20</b>	<b>Total</b>	<b>0-17</b>	<b>18-20</b>	<b>Total</b>	<b>0-17</b>	<b>18-20</b>	<b>Total</b>
AFDC	411,833	23,871	435,704	432,141	24,646	456,787	5%	3%	5%
SCHIP A	49,316	5,703	55,019	52,313	6,580	58,893	6%	15%	7%
DCF	23,083	977	24,060	24,083	1,151	25,234	4%	18%	5%
SSI	27,939	5,443	33,382	28,264	5,559	33,823	1%	2%	1%
<b>Total</b>	<b>512,171</b>	<b>35,994</b>	<b>548,165</b>	<b>536,801</b>	<b>37,936</b>	<b>574,737</b>	<b>5%</b>	<b>5%</b>	<b>5%</b>

**Table 19** shows the Medicaid penetration rates, the rate at which children that are enrolled in Medicaid use mental health services. Overall, there was a small increase in the use of Medicaid behavioral health services among youth and young adults enrolled in Medicaid. This suggests that the Medicaid system mental health system has kept up with its growing service population and has even slightly increased the penetration rate.

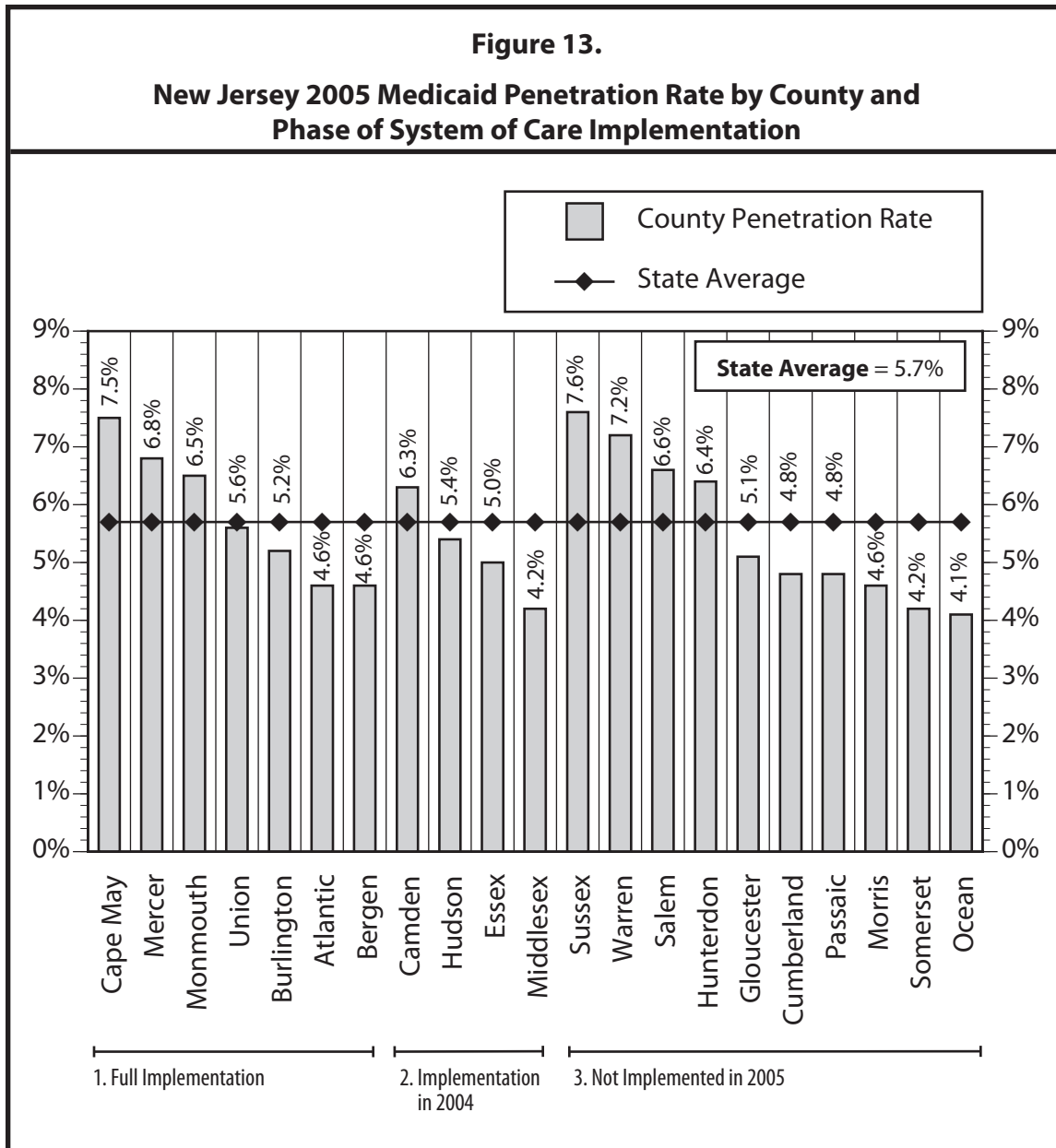
The highest risk group, children who are Medicaid eligible because they are in the custody of DCF, show the highest rates of penetration, particularly those who are 18 and over, where 60% to 2/3 use mental health services. Approximately 30% of younger children in DCF custody use mental health services. Rates of utilization, however, dropped between 2004 and 2005. Since the utilization rates remain very high, these decreases may not be a problem, but warrant further scrutiny given the vulnerability of this group. The utilization of disabled children on SSI is also very high, with approximately 20% of disabled children and young adults using mental health services. AFDC and SCHIP rates were considerably lower, falling between 3% and 5%, but utilization grew at a high 9% rate for SCHIP youth, while utilization of SCHIP young adults fell somewhat.



Table 19.									
New Jersey Medicaid Behavioral Health Penetration by Eligibility Category									
Eligibility Category	2004			2005			Percentage Change		
	0-17	18-20	Total	0-17	18-20	Total	0-17	18-20	Total
AFDC	3.4%	4.5%	3.5%	3.6%	4.7%	3.7%	5%	4%	5%
SCHIP A	4.6%	3.9%	4.5%	5.0%	3.8%	4.9%	9%	-4%	8%
DCF	30.1%	67.5%	31.6%	27.7%	59.6%	29.1%	-8%	-12%	-8%
SSI	19.8%	20.9%	20.0%	21.1%	20.3%	20.9%	6%	-3%	5%
<b>Duplicated Total</b>	<b>5.6%</b>	<b>8.6%</b>	<b>5.8%</b>	<b>5.7%</b>	<b>8.5%</b>	<b>5.9%</b>	<b>2%</b>	<b>-1%</b>	<b>2%</b>

The following chart shows that Medicaid penetration rates ranged from 4% to 7%, showing less variation than many of our other measures of service provision.

This chart sorts counties by their phase of systems of care implementation, and shows no apparent influence of this process on Medicaid penetration.



We did not analyze Non-Medicaid services separately because we had only those non-Medicaid services from phase 1 and 2 counties that had migrated to the consolidated billing system, and many children were not identified with a specific county.

## Expenditures

**Table 20** shows how consolidated Medicaid and non-Medicaid expenditures were distributed between inpatient, residential and outpatient and that they changed over the two years as would be expected from implementing a system of care. Overall, these expenditures increased by 3%, less than the increase in children served, indicating that access was

increased at a greater rate than expenditures increased. This suggests the possibility that the children's service system is providing services more efficiently or realizing economies of scale. This modest overall increase was composed of increases of 8% and 11% in community and outpatient services for youth and young adults and an even larger increase in inpatient services only for young adults. Balancing those increases were significant decreases in inpatient services for youth and residential services for young adults, with a smaller decrease in residential services for youth. These changes in service use and their associated expenditures illustrate the ability of systems of care to self-finance a portion of the necessary expansion in community services. Increases were greater for young adults aged 18 to 20, which increased by 5% overall, while expenditures for younger youth averaged a modest 2%.

<b>Table 20.</b> <b>New Jersey Children's Consolidated Mental Health Services Expenditures</b> <b>by Age and Level of Care</b>									
	2004			2005			Percentage Change		
	\$	\$	\$	\$	\$	\$	%	%	%
	0-17	18-20	Total	0-17	18-20	Total	0-17	18-20	Total
Inpatient	31,168	6,305	37,473	26,105	7,210	33,316	-16	14	-11
Residential	52,783	6,261	59,045	51,313	5,185	56,499	-3	-17	-4
Outpatient/ Community	149,711	12,148	161,860	162,02	13,452	175,478	8	11	8
<b>Total</b>	<b>233,664</b>	<b>24,715</b>	<b>258,380</b>	<b>239,444</b>	<b>25,848</b>	<b>265,293</b>	<b>2</b>	<b>5</b>	<b>3</b>

Medicaid funding accounted for 84% and 83% of total expenditures in 2004 and 2005. Medicaid covers almost all inpatient services, and all residential services, and approximately three quarters of outpatient and community services. Medicaid expenditures increased very modestly, at just 2% overall, indicating that most of the increased expenditures came through increased Non-Medicaid funding. Given its dominance in overall spending, the between year changes of the different age and level groups are similar to those for overall spending.

Non-Medicaid spending increased overall by 9%, but we cannot assume that this is growth since it may represent transfer from the agency based contracting system onto the consolidated billing system, rather than new funding. However, it is notable that the relatively small amount of expenditures for inpatient services actually decreased substantially – by almost half, indicating dramatic changes in how these funds are being used, possibly in part due to the closing of Brisbane State Hospital. This data base indicates that state funds are not being used for non-Medicaid residential at all. The bulk of state funds are used for community/outpatient services which increased by 10% on average, and at an even higher rate of 21% for young adults.

<b>Table 21.</b> <b>New Jersey Children's Non-Medicaid Mental Health Service Expenditures</b> <b>by Age and Level of Care (000s) (Consolidated Claims Only)</b>									
Non-Medicaid	2004			2005			Percentage Change		
	\$	\$	\$	\$	\$	\$	%	%	%
	0-17	18-20	Total	0-17	18-20	Total	0-17	18-20	Total
Inpatient	818	72	890	429	40	467	-47	44	-47
Residential	0	0	0	0	0	0	n/a	n/a	n/a
Outpatient/Community	36,781	3,119	39,901	40,074	3,768	43,843	9	21	10
<b>Total</b>	<b>37,599</b>	<b>3,191</b>	<b>40,791</b>	<b>40,504</b>	<b>3,808</b>	<b>44,313</b>	<b>8</b>	<b>18</b>	<b>9</b>

We compared these expenditure figures to the new DCBHS budget for FY2006, its first budget as its own entity. According to this budget, there is considerably more funding in the children's behavioral health system than Non-Medicaid funding in the Consolidated billing system in 2005. Some of the costs not included in the consolidated data are start up costs for CMOs, FSOs and MRSS, as well as certain ongoing expenditures classified as administrative rather than direct service. In comparing New Jersey to other states, it will be necessary to remember that additional funds expended for children's mental health are not included in our data, and some additional children are reached by those services.

<b>Table 22.</b> <b>New Jersey's DCBHS FY 2006 Budget</b>			
Service Type	State	Federal	Total
MRSS	\$9,031	\$2,375	\$11,406
YCM	\$6,333	\$2,137	\$8,470
YIP	\$7,359	\$933	\$8,292
Intensive in COMM	\$20,540	\$12,744	\$33,284
FSO	\$6,191	\$2,541	\$8,732
CMO	\$31,142	\$9,489	\$40,631
Out-of-Home Treatment	\$142,545	\$76,747	\$219,292
<b>Total Grants in Aid</b>	<b>\$223,141</b>	<b>\$106,966</b>	<b>\$330,107</b>

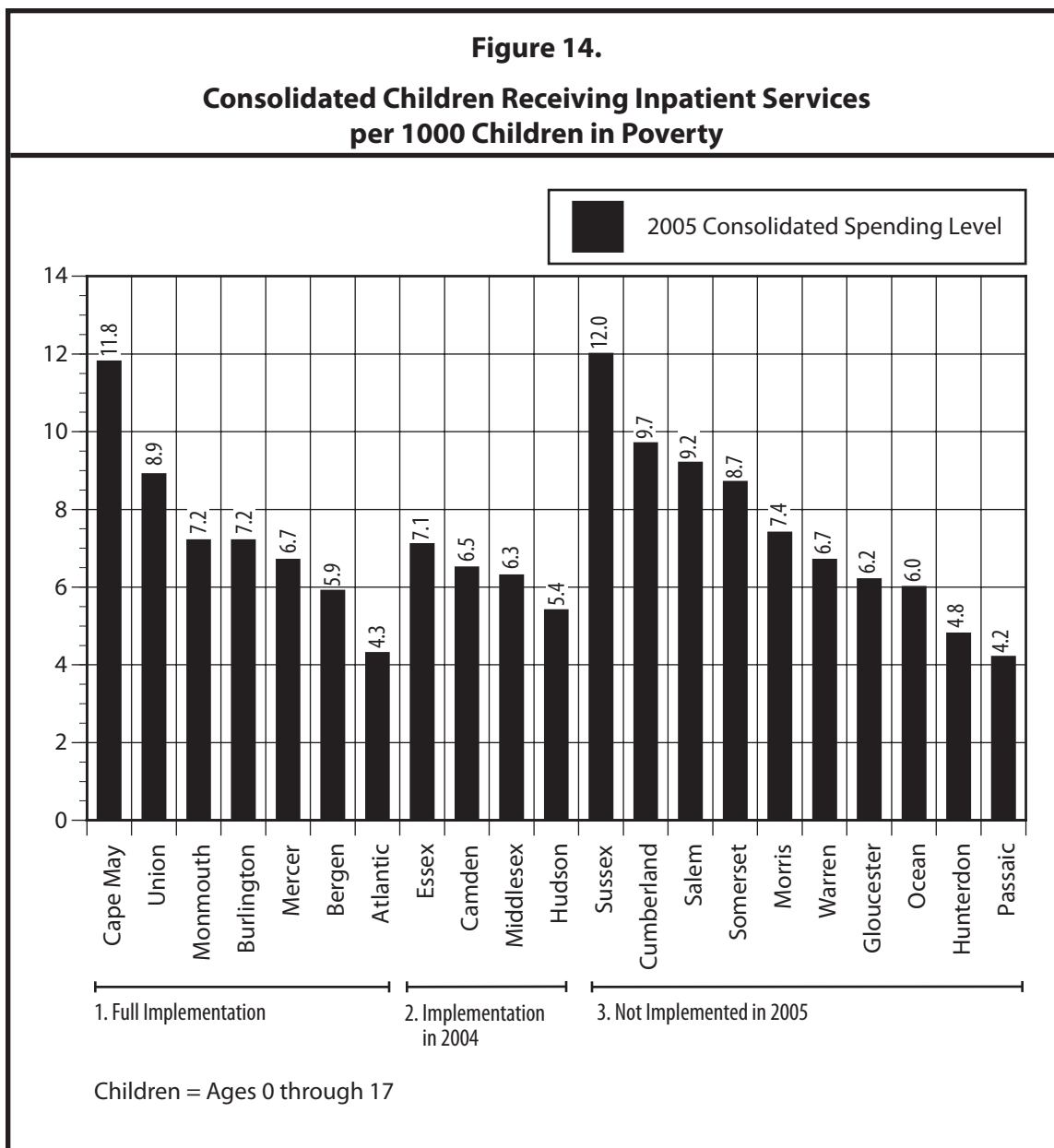
New Jersey's average level of expenditures for each child served in the consolidated system is presented below. Given the missing non-Medicaid expenditures in phase three counties, they are somewhat understated. Overall, New Jersey slightly decreased the average cost per child served. Decreases of 12% in inpatient average costs for children and youth more than offset a steep increase in inpatient cost for young adults, and more modest increases in residential average costs.

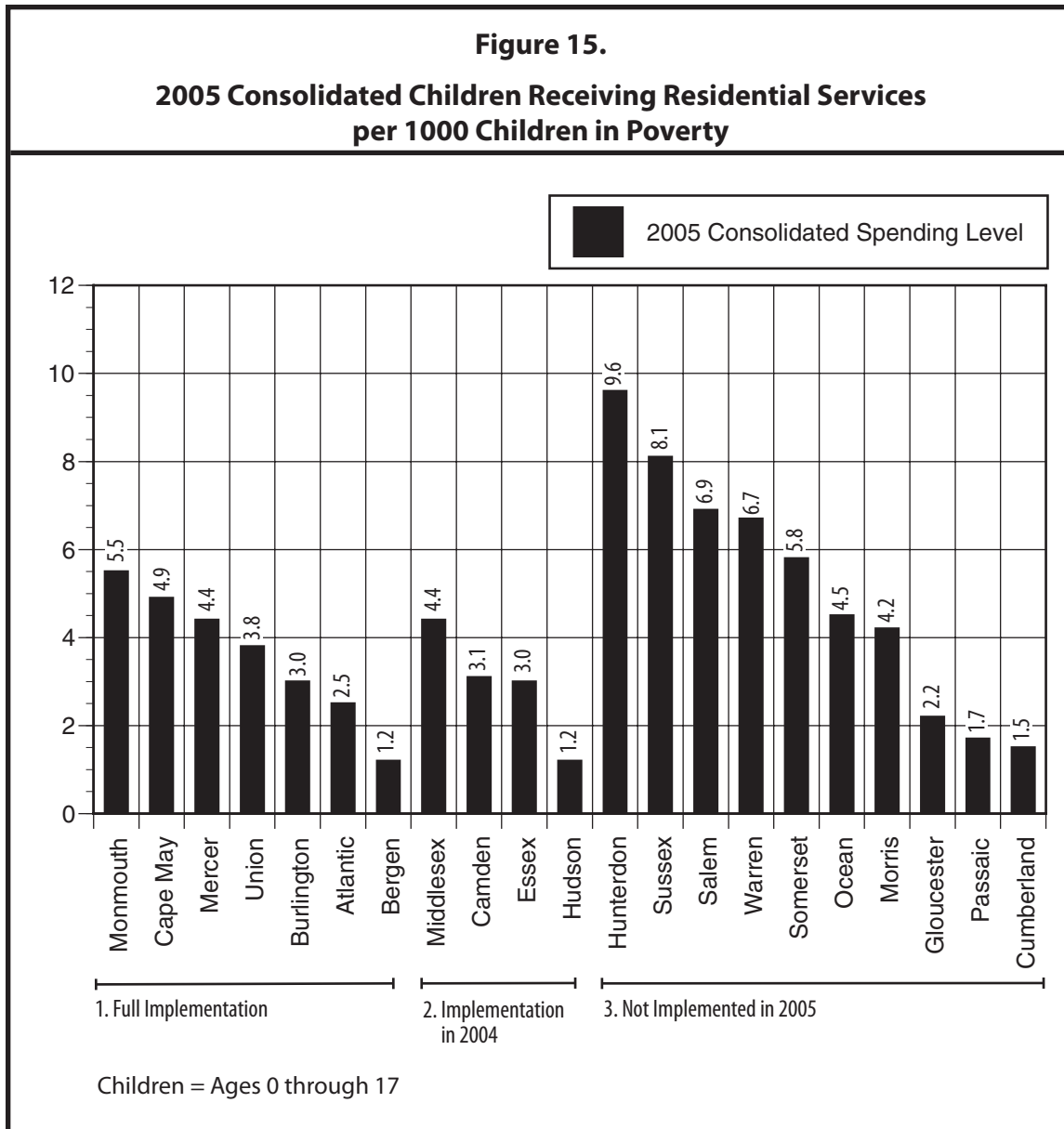
<b>Table 23.</b> <b>New Jersey Medicaid Behavioral Health Expenditures</b> <b>per Child Served by Level of Care</b>									
	2004			2005			Percentage Change		
	0-17	18-20	Total	0-17	18-20	Total	0-17	18-20	Total
Inpatient	\$15,822	\$12,816	\$15,221	\$13,901	\$15,882	\$14,286	-12%	24%	-6%
Residential	\$58,976	\$50,497	\$57,944	\$61,823	\$55,763	\$61,213	5%	10%	6%
Outpatient/ Community	\$5,199	\$3,715	\$5,048	\$5,204	\$3,899	\$5,074	0%	5%	1%
<b>Total Expenditures*</b>	<b>\$ 7,381</b>	<b>\$6,360</b>	<b>\$ 7,269</b>	<b>\$ 7,076</b>	<b>\$6,467</b>	<b>\$7,011</b>	<b>-4%</b>	<b>2%</b>	<b>-4%</b>
*Total expenditures are divided by a duplicated total of service users that double counts those children receiving services in more than one service category over the year.									

Expenditures increased more for young adults aged 18 to 20 than for younger youth. As is desired in a system of care, increased expenditures for community and outpatient services for youth and young adults are balanced by decreases in inpatient services for youth and residential services for all youth and young adults. However, there was a large increase in young adult inpatient services. This changing service use pattern illustrates the potential of systems of care to self-finance a portion of the necessary expansion in community services.

## Use of Out of Home Treatment

We further examined the use of out of home care, stratifying by county to see how systems of care implementation may have affected it. **Figures 14** and **15** show the rate at which counties are using inpatient and residential services per thousand in poverty. There appears little difference in the way that system of care has affected the number of children using inpatient services. Both phase 1 and phase 3 counties use inpatient services at a similar rate, with phase 2 showing a smaller range in rates for its smaller number of counties. But the use of residential appears to have shifted considerably with the implementation of systems of care. Phase 1 and Phase 2 counties use residential for fewer children than do Phase 3 counties who had not yet implemented systems of care.

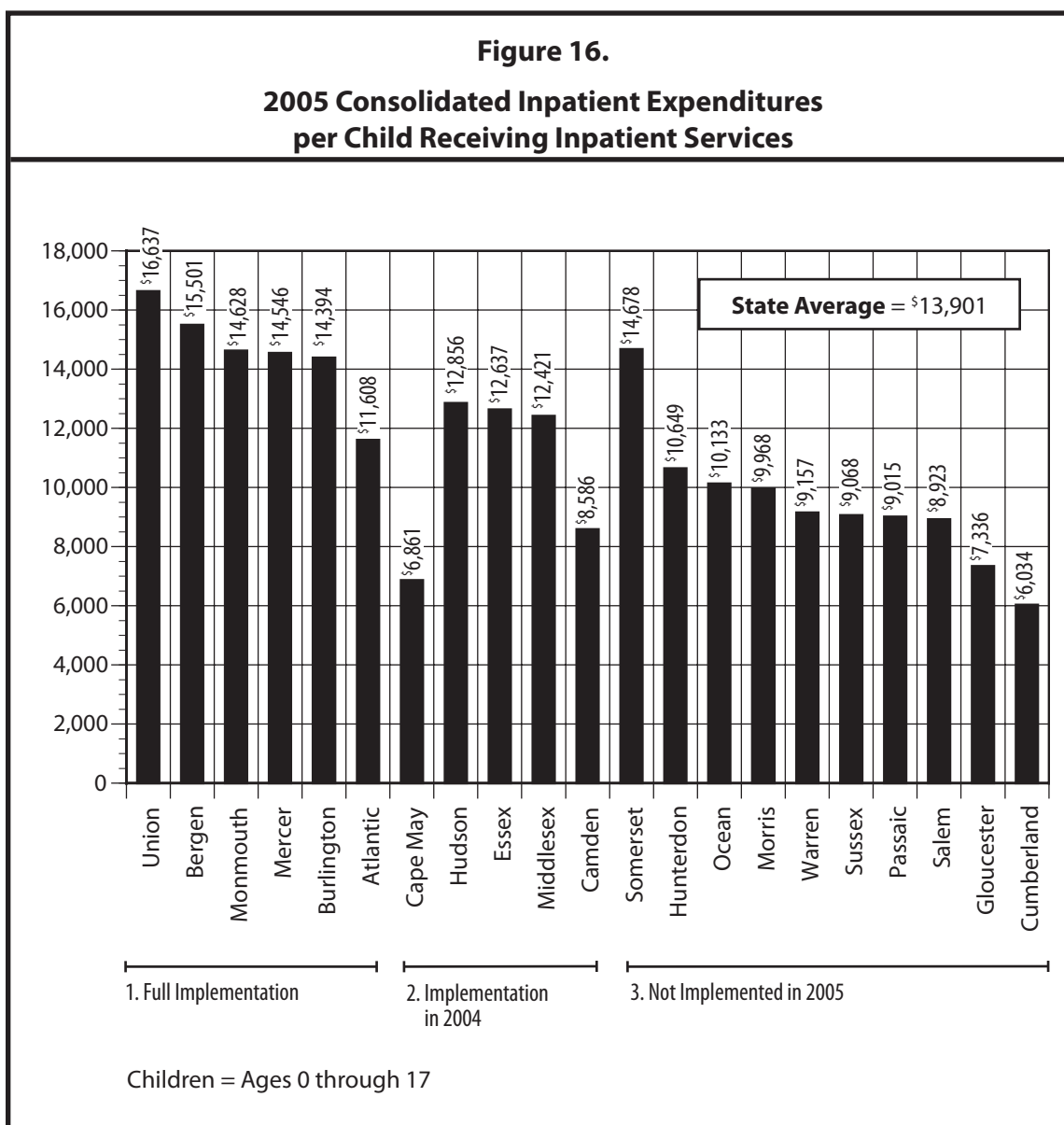


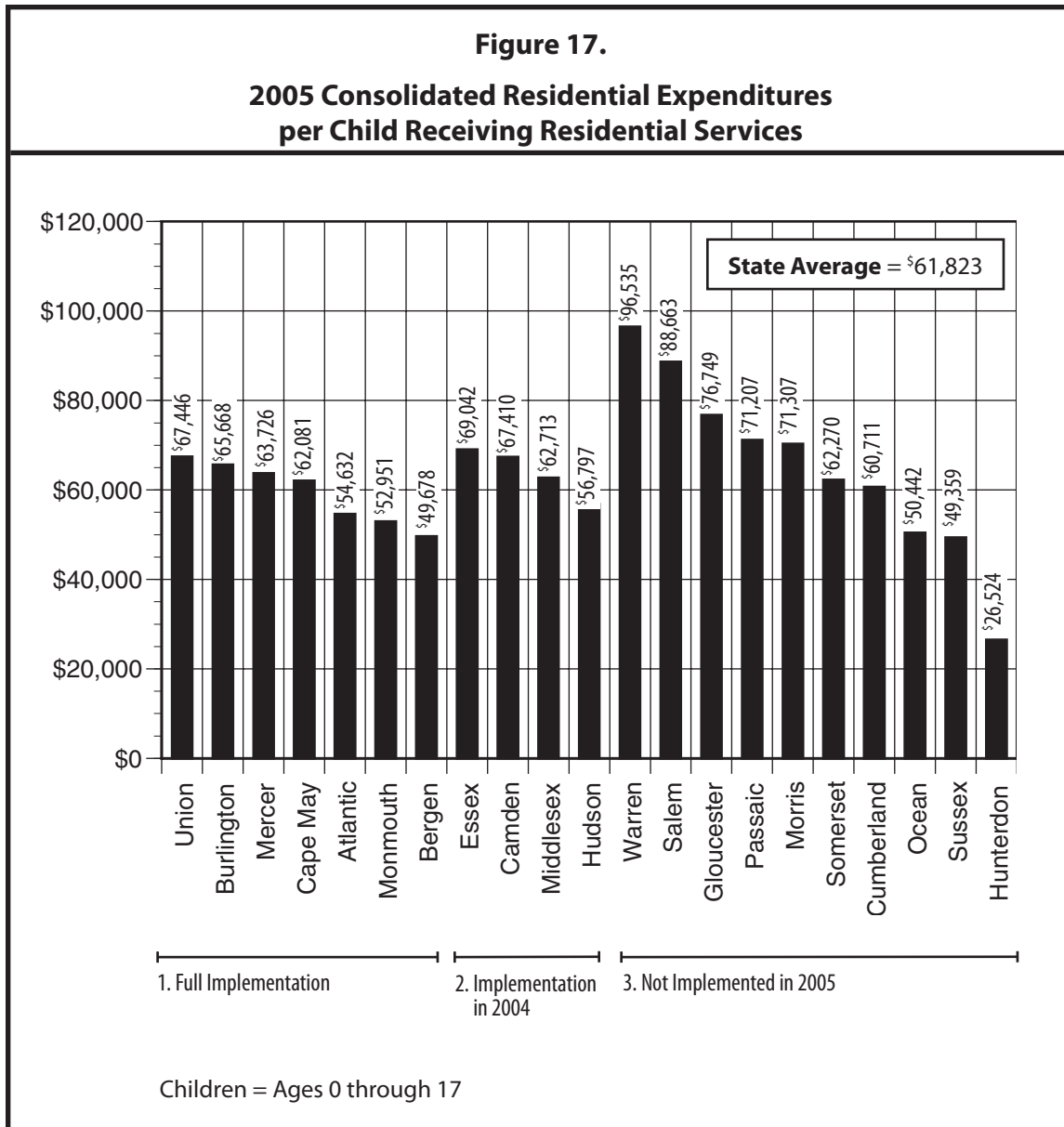


We also examined in cost per child served on a county basis. In our original study, New Jersey spent the bulk of its children's mental health service expenditures, 72%, on inpatient and residential care. The percent of total expenditures utilized for residential and inpatient services ranged from 48% (a significant outlier) to 85%. This picture has changed considerably in all counties. In 2005, the statewide average was 39% spent on inpatient and residential care. Ocean County had the lowest rate, 20% and Warren County the highest at 56%.



In **Figures 16 and 17**, we see some differences between counties in their use of inpatient and residential. Counties further in the process of system of care implementation had higher expenditures per child served in inpatient and lower per child costs for residential. In residential, there was considerable reduction in variation in the phase 1 and 2 counties which had a smaller range of average costs. On average, however, residential costs per child were very similar in all three phases.





Overall, it appears that systems of care counties tend to have similar numbers of children using inpatient care, but children admitted have longer stays or more admissions than those who have not implemented. Systems of care counties sent fewer children to residential care, and had slightly shorter lengths of stay for those who did use this level of care than the counties who were just beginning to implement systems of care. Possibly, inpatient services are being substituted for residential placements in the system of care counties. Since inpatient stays are shorter than residential stays, this practice may minimize children's time away from home. Our statewide data showed inpatient costs trends for 18 to 20 year olds increasing considerably from 2004, in contrast to declining costs for younger youth. Stratifying inpatient data may assist the state to better understand these trends.

# New Jersey’s Consolidated System Compared to Other Entities

Our analysis showed that New Jersey’s system of care services and its overall public mental health system are meeting a relatively small share of children’s need for services (see **Table 4**). Since access to behavioral health for children is a national problem, it would be valuable to find some context to evaluate New Jersey’s performance. To do so, we requested utilization and expenditure data from several states and counties that have reasonable similarities to New Jersey. We were particularly interested in states demographically similar to New Jersey, like the Southeastern Counties of Pennsylvania; Maryland and Massachusetts. In addition, we included entities that have implemented some aspect of systems of care, including more urban Minnesota counties around Minneapolis St. Paul, Milwaukee County, and Maricopa County (Phoenix) Arizona. Again, since Pennsylvania’s Medicaid system incorporates many system of care principles, the SE PA counties also meet this criterion.

## Description of Comparison Entities

A table in **Appendix G** summarizes the key characteristics of each comparison.

Table 24. Comparison Entities	
State or County	System Description
South Eastern Pennsylvania Counties	SE Pennsylvania Counties serve as mental health authorities, managing or overseeing carved out Medicaid mental health services, as well as administering state and county funds for children’s mental health. We added together data from Delaware, Montgomery, Bucks, and Philadelphia Counties. Each has a Child and Adolescent Service System Program (CASSP) infrastructure to serve children with or at risk for serious disorders and a CASSP Coordinator.
Maryland	The state of Maryland has a behavioral health carve out managed by its counties and a statewide Administrative Services Organization (ASO), which also is a conduit for certain non-Medicaid services.
Massachusetts	Massachusetts provides a comprehensive Medicaid behavioral health benefit through HMOs, a behavioral health carve out partnered with its Primary Care Physician Plan (PCCP) plan, and some fee for service. It provided data that included substance abuse services. Its Mental Health Authority also provided data. We were unable to assign all of its service related costs to a level of care, somewhat understating its expenditures. Approximately 45% of children served by the MHA also get Medicaid services.

**Table 24.**  
**Comparison Entities**

Continued

State or County	System Description
Minneapolis/ St. Paul/ Bloomington Metropolitan Statistical Area	We combined data for Census identified counties closely linked to Minneapolis and St. Paul, creating a more urbanized region than the state overall. Minnesota has state oversight of a county administered system and many of its counties have implemented systems of care. They produce annual utilization reports that integrate data from their reporting system to the state MHA and the Medicaid system, which also includes some state funded coverage similar to Medicaid. Any tribal services are excluded.
Milwaukee County, Wisconsin	A recent study determined the number of children receiving mental health services through Medicaid, SCHIP, County mental health services, Wraparound Milwaukee, and state programs offering coverage similar to Medicaid. They unduplicated these figures to come up with their number of children served. <b>WrapAround Milwaukee</b> is a pioneering system of care serving the county. It accepts only children determined to be at risk of residential or correctional placement and receives capitation payments from a combination of Medicaid, the child welfare agency and the courts. A high proportion of children served are court involved.
Maricopa County, Arizona	Maricopa County (surrounding Phoenix) is the largest region of a statewide managed care behavioral health carve out that includes Medicaid and some state services. A statewide settlement agreement focused on the children's behavioral health system and resulted in the development of comprehensive children's system transformation requiring provider agencies to implement child and family teams to plan services for their children, and to create comprehensive networks of services and supports needed to carry out the plans.

## Demographic Comparison

The following table provides demographic comparisons about the states, counties and county groups that are being compared to New Jersey. New Jersey is the largest entity, with a total 2005 census estimated population of almost 9 million. Massachusetts and Maryland follow, with 6 and 5.6 million respectively. The Counties in Southeastern Pennsylvania are similar in size to Minnesota counties in the Minneapolis Saint Paul metropolitan statistical area, and the single Arizona county of Maricopa, which includes the city of Phoenix. Milwaukee County, with not quite 1 million in population, is the smallest entity included.

Maricopa County has the fastest population growth rate between 2000 and 2005, at 18%, far higher than the next fastest growing communities of Maryland and Minneapolis/Saint Paul at about 6%. New Jersey grew at 3.6%, higher than Massachusetts, the SE PA counties and Milwaukee which were stagnant or even decreased in population.

New Jersey falls between the extremes for most demographic measures presented. It is on the higher ends for income, urbanization and diversity. Notably, it appears to have a greater number of sizeable ethnic groups, with significant concentrations of Asians, Latinos, African Americans and people speaking a language other than English. This degree of diversity may create more complicated challenges than entities serving fewer groups.

<b>Table 25.</b> <b>Selected Census Bureau people QuickFacts Measures New Jersey</b> <b>Compared to Other Entities</b>							
<b>Census Bureau People QuickFacts Measures</b>	<b>New Jersey</b>	<b>Maryland</b>	<b>SE PA Counties</b>	<b>Milwaukee County</b>	<b>MN ST PI1</b>	<b>Massachusetts</b>	<b>Maricopa County</b>
Population, 2005 estimate	8,717,925	5,600,388	3,416,154	921,654	3,350,862	6,398,743	3,635,528
Population, percent change, April 1, 2000 to July 1, 2005	3.6%	5.7%	0.0%	-2.0%	5.6%	0.8%	18.3%
Persons under 5 years old, percent, 2004	6.7%	6.7%	6.5%	7.6%	7.0%	6.2%	8.3%
Persons under 18 years old, percent, 2004	24.8%	25.1%	24.5%	26.1%	25.3%	22.8%	27.7%
White persons, percent, 2004 (a)	76.9%	64.5%	69.4%	68.4%	87.0%	87.0%	89.3%
Black persons, percent, 2004 (a)	14.5%	29.1%	24.6%	26.1%	5.9%	6.8%	4.2%
Asian persons, percent, 2004 (a)	7.0%	4.6%	4.5%	2.9%	4.6%	4.6%	2.6%
Persons of Hispanic or Latino origin, percent, 2004 (b)	14.9%	5.4%	5.5%	10.5%	4.1%	7.7%	28.3%
White persons, not Hispanic, percent, 2004	63.8%	59.8%	64.8%	58.9%	83.3%	80.8%	62.5%
Foreign born persons, percent, 2000	17.5%	9.8%	13.0%	6.8%	6.6%	12.2%	14.4%
Language other than English spoken at home, pct age 5+, 2000	25.5%	12.6%	10.1%	13.1%	10.0%	18.7%	24.1%
High school graduates, percent of persons age 25+, 2000	82.1%	83.8%	80.6%	80.2%	90.2%	84.8%	82.5%
Bachelor's degree or higher, pct of persons age 25+, 2000	29.8%	31.4%	26.8%	23.6%	32.2%	33.2%	25.9%
Persons with a disability, age 5+, 2000	1,389,811	854,345	621,127	169,939	405,448	1,084,746	504,992
Percent with a disability, age 5+	16.5%	16.1%	19.4%	18.1%	13.7%	17.1%	16.4%
Housing units in multi-unit structures, percent, 2000	36.1%	25.8%	26.9%	48.5%	27.0%	42.7%	26.6%

Table 25.							Continued
Selected Census Bureau people QuickFacts Measures New Jersey Compared to Other Entities							
Census Bureau People QuickFacts Measures	New Jersey	Maryland	SE PA Counties	Milwaukee County	MN ST PI1	Massachusetts	Maricopa County
Median value of owner—occupied housing units, 2000	\$ 170,800	\$ 146,000	\$58,700- \$163,200	\$ 103,200	\$99,100- \$170,200	\$ 185,700	\$ 129,200
Persons per household, 2000	2.7	2.6	2.6	2.4	2.8	2.5	2.7
Per capita money income, 1999	\$ 27,006	\$ 25,614	\$16,509- \$30,898	\$19,939	\$19,008- \$28,789	\$ 25,952	\$ 22,251
Median household income, 2003	\$ 56,356	\$ 54,302	\$30,414- \$65,234	\$ 39,085	\$45,354- \$74,127	\$ 52,713	\$ 46,322
Persons below poverty, percent, 2003	8.9%	8.8%	12.3%	16.2%	7.4%	9.5%	12.8%
Federal spending, 2004 (\$1000) Per capita	\$63,392	\$115,574	\$8,036	\$6,406	\$4,887	\$83,017	\$5,859
Land area, 2000 (square miles)	7,417	9,774	1,409	242	8,268	7,840	9,203
Persons per square mile, 2000	1,134	542	2,425	3,892	384	810	334
Note: All multi-county percentages are computed as weighted averages applying the county rate to the 2000 or 2005 county population, whichever is the year closest to the year to which the rate applies. For rates applicable to ages 5 and above, the county population was estimated using the 2004 rate of children under age 5 times the 2005 population. For rates applicable to ages over 25, the county population was estimated using the 2004 rate of adults 18 and over times the 2005 population. This method will tend to understate multi-county rates. For Median values, a range of the highest and lowest county medians is shown.							

## Comparison of Medicaid Penetration

We were able to make several comparisons of New Jersey's Medicaid penetration to other entities. A study conducted by Dougherty Management Associates, Inc., The Children's Mental Health Benchmarking Project, offers historical comparison data from a large number of states and several counties. Most of the counties were major metropolitan areas with populations greater than at least half the states included in the study, and most of the data were from 2000 and 2001. The mean and median of the entities that were able to provide data representing all their Medicaid services was 10%, considerably higher than New Jersey's penetration rate of 5.8% and 5.9% in 2004 and 2005. In fact, New Jersey fell at the bottom of the range, with Georgia and Tennessee, who reached 6% of their Medicaid eligible individuals.

**Figure 18.**

**Medicaid Penetration**

**Total Yearly Enrollment**

**Number of children receiving a Medicaid funded mental health service divided by the number of children enrolled in Medicaid**

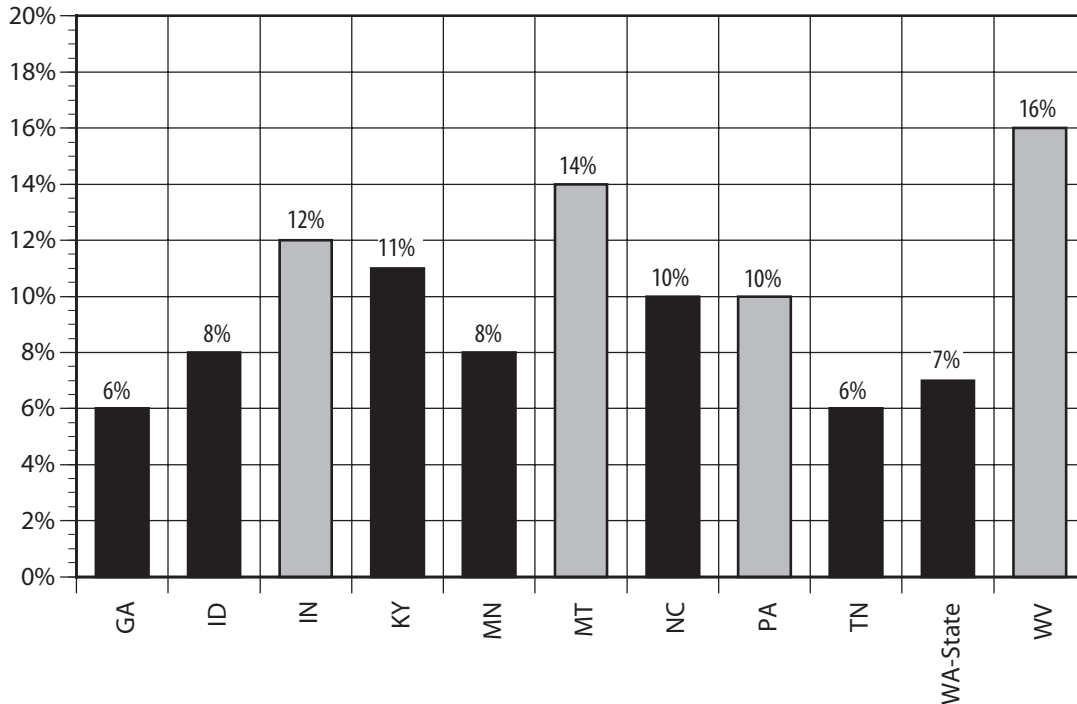
Mean=10%

Median = 10%

SD = 3%

 No PCP Services

 Include PCP Services



**Footnotes for Figure 18. Medicaid Penetration**

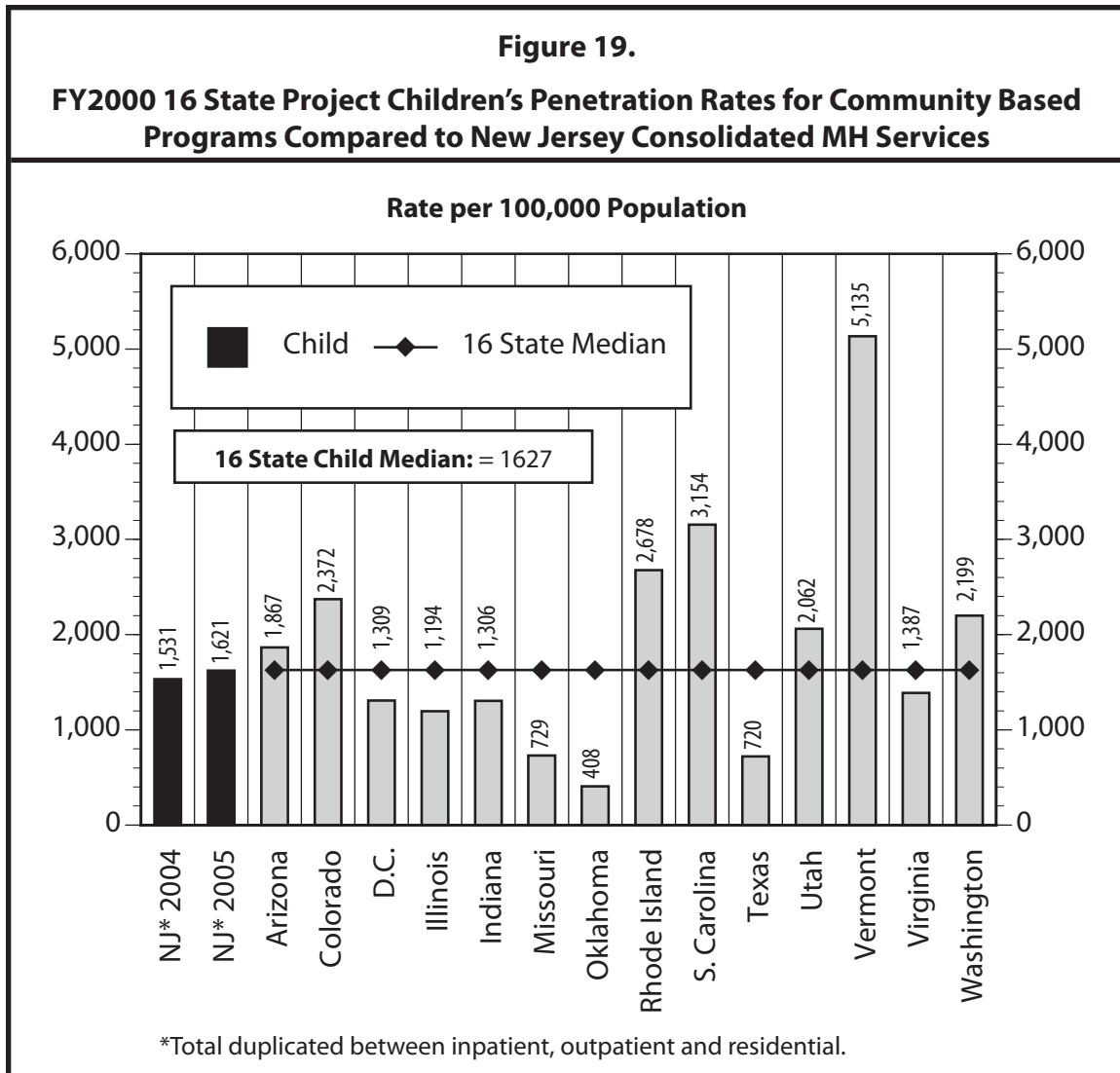
Idaho	Excludes any children receiving Medicaid residential care and no other mental health service.
Indiana	Includes children in any Medicaid residential facility that have a primary MH diagnosis, including those in Intermediate Care Facilities-Mental Retardation (ICF-MR).
Minnesota	Includes enrollees in MinnesotaCares, a state program similar to SCHIP financed by state and federal funds.
Wyoming	Includes services provided by mental health practitioners billing under a physician's provider number.



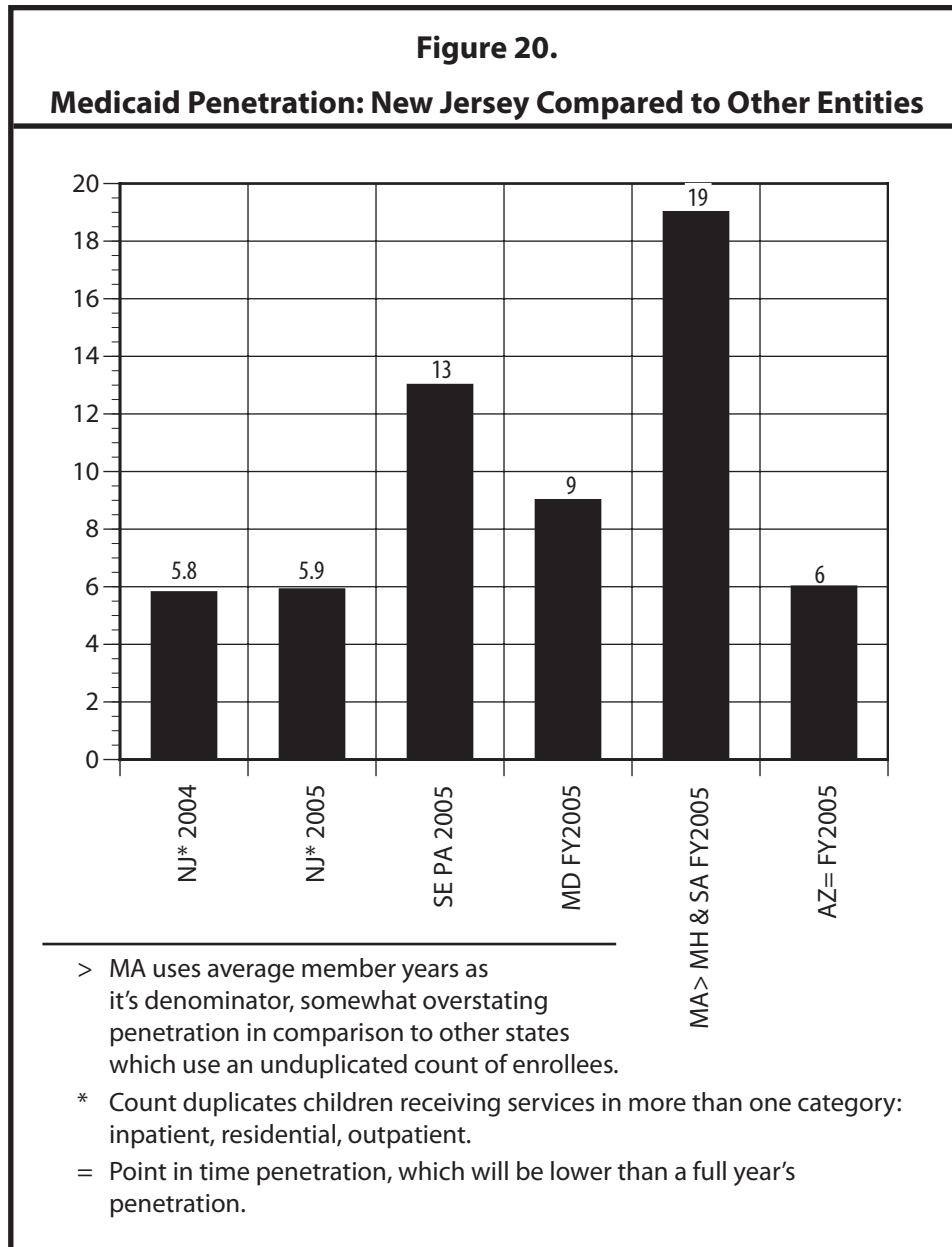
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The Health Employer Data Information Sets (HEDIS) measures the performance of managed care organizations. It calculates national averages for its broad range of participating Medicaid HMOs. In many states, higher need groups, like children in state custody or disabled children, are not required to enroll in managed care. This national average is, therefore, more useful as a comparison to the rates of AFDC and SCHIP Plan A Children. The mean mental health penetration rate for national Medicaid Health Plans in 2005 was 3.8% for children under 13, and the median was 3.3%. The mean penetration rate for children between 13 and 17 was 8.0%, with a median of 7%. New Jersey's penetration rates for AFDC of 3.4% - 3.6% for 0 to 17 year olds seem quite low in comparison as do its somewhat higher penetration rates of 4.6% to 5.0%.

The SAMHSA-sponsored 16 state pilot study of selected mental health benchmarks includes the following measure of children served in community based services by state Mental Health Authorities per hundred thousand children in the population. We have added New Jersey's 2004 and 2005 rates, based on our duplicated totals from the Consolidated service data we received and Census estimates of the 2004 and 2005 population of 0 to 20 year olds. This is a more expansive set of services than would be counted by most mental health authorities, which would not include Medicaid services provided outside of their community mental health centers. However, New Jersey's 2005 consolidated service provision, doesn't quite reach the median of FY2000 for this set of states.

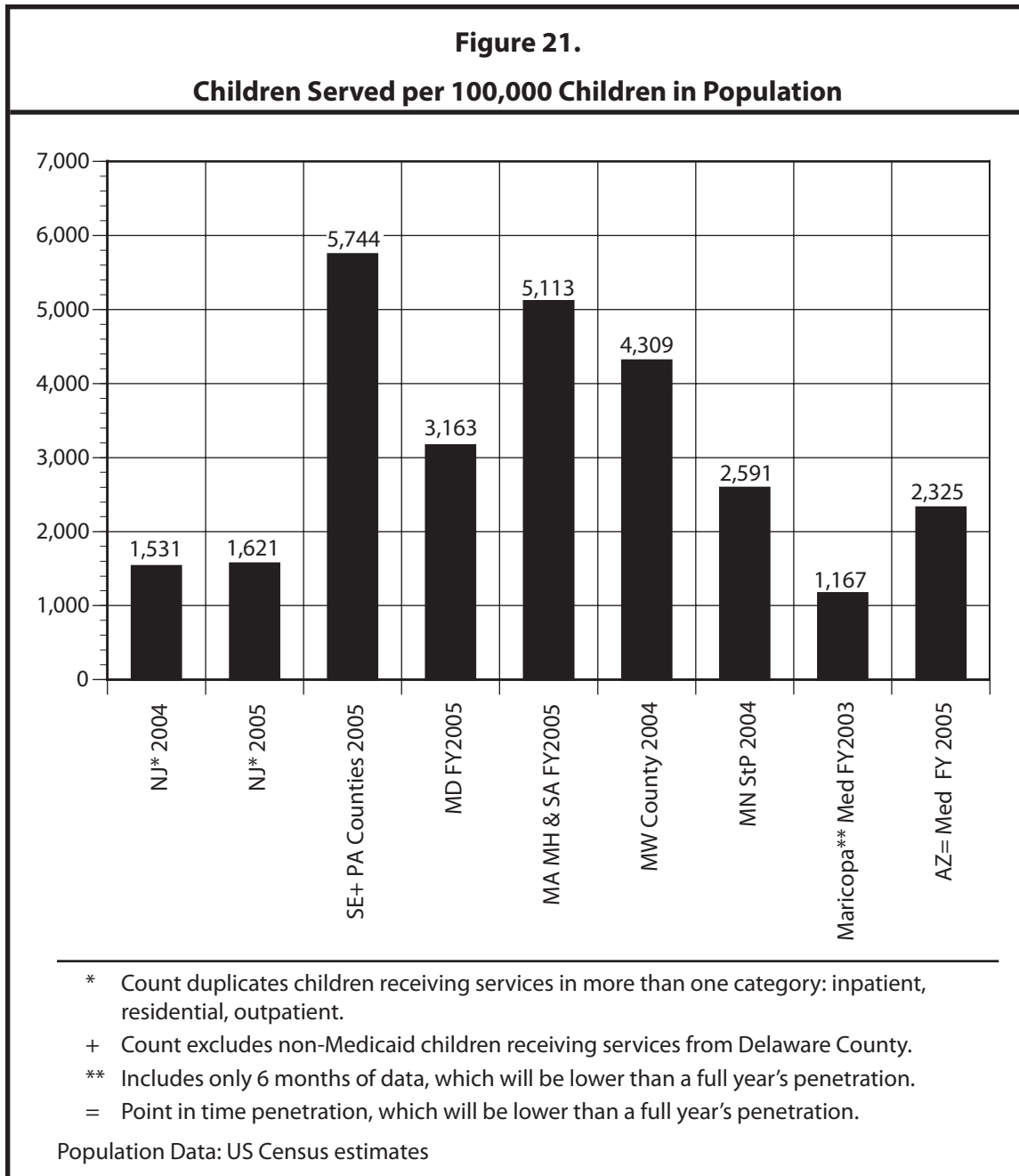


Finally, we compared New Jersey to the data collected for this project. The following figure shows the characteristics of the Medicaid data we are able to collect for a more up to date comparison of New Jersey. It is important to note that, because of its method of calculating penetration, Massachusetts' rates will be overstated compared to New Jersey, and its inclusion of substance abuse also increases its rate. However, as seen in **Figure 20**, New Jersey's Medicaid penetration again falls toward the bottom of the range.



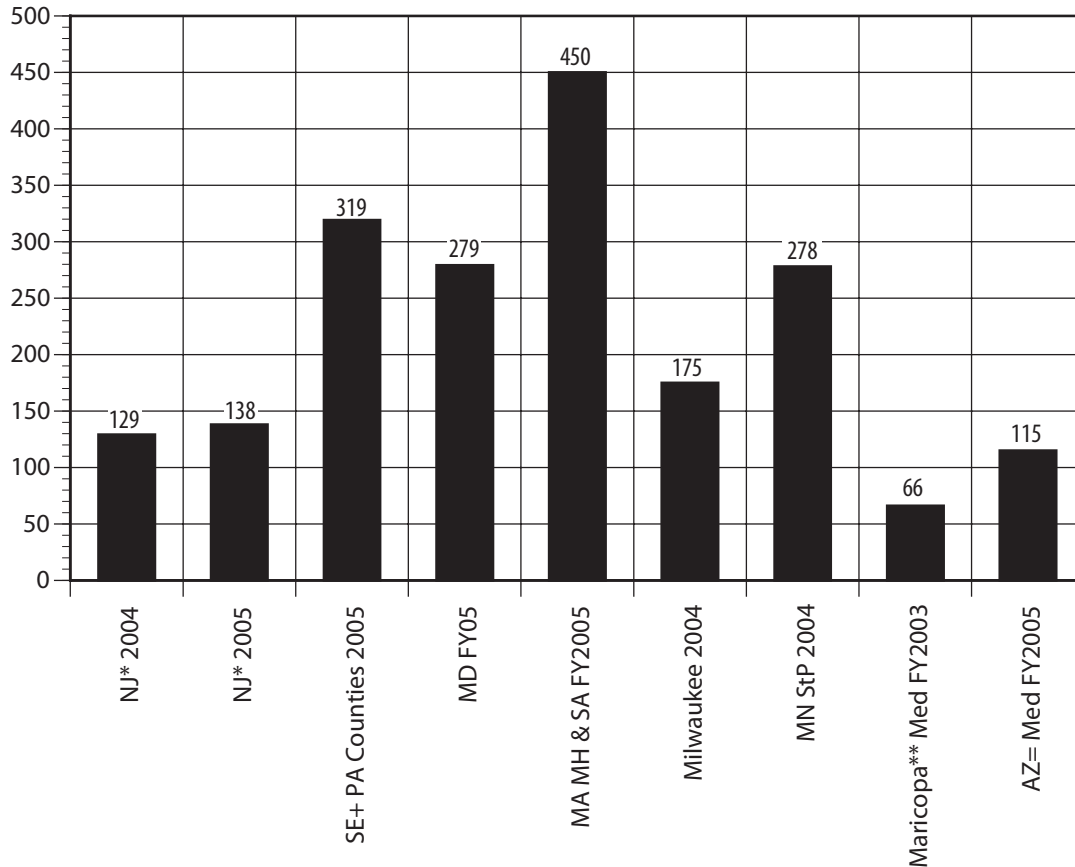
\*It is important to note, we totaled Medicaid and non-Medicaid children using services, a method that likely involves duplication, since children may receive non-Medicaid services before or after a period of Medicaid eligibility. While this produces higher estimates in most states, it may affect them differently, since the degree of overlap may differ between them.

We also compared available data on total children served by either the Medicaid or the Mental Health Authority programs. As seen in **Figure 21**, there is considerable variation in these figures, with New Jersey appearing toward the bottom of the range, followed only by Maricopa County in 2003. However, Maricopa County's figure is based on 6 months of data. With another six months to provide services, the number of unduplicated users there would be larger.



Looking at provision of services in comparison to the population of children in poverty can help to adjust for the demographic differences between states, and puts attention on the class of children most likely to be eligible for public behavioral health services. As shown in **Figure 22**, this measure puts New Jersey above Arizona and reduces the magnitude of the gap between New Jersey and the states that provide greater access. It also changes the relative position of other entities to each other. Nonetheless, the gap remains considerable.

**Figure 22.**  
**Children Served per 100,000 Children in Poverty: New Jersey Consolidated  
 Compared to Medicaid & Mental Health Authority<sup>++</sup>**

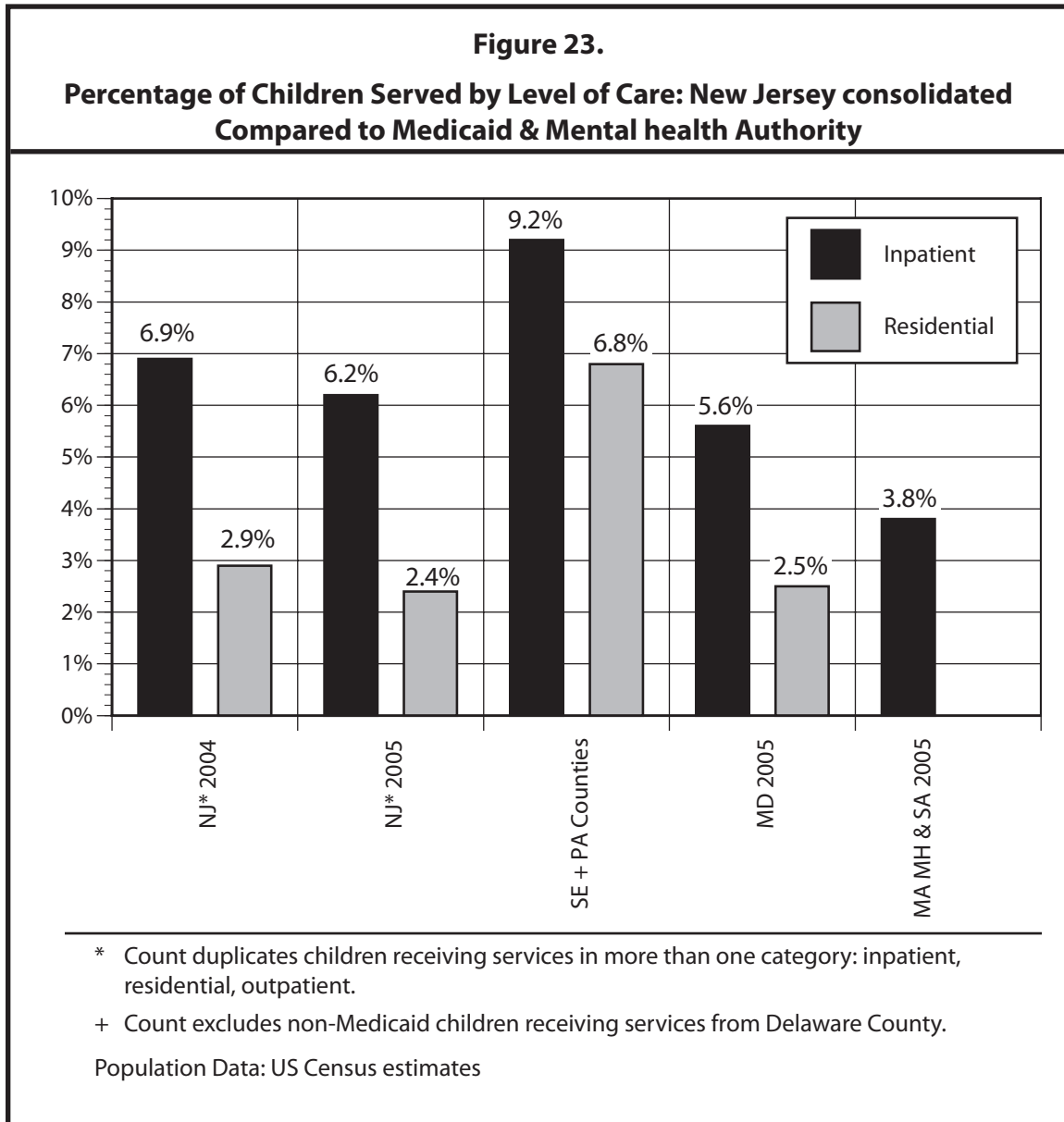


- \* Count duplicates children receiving services in more than one category: inpatient, residential, outpatient.
- + Count excludes non-Medicaid children receiving services from Delaware County.
- \*\* Includes only 6 months of data, which will be lower than a full year's penetration.
- = Point in time penetration, which will be lower than a full year's penetration.
- ++ It is important to note, we totaled Medicaid and non-Medicaid children using services, a method that likely involves duplication, since children may receive non-Medicaid services before or after a period of Medicaid eligibility. While this produces higher estimates in most states, it may affect them differently, since the degree of overlap may differ between them.

Population Data: US Census estimates

We were able to compare the degree to which entities used different levels of care.

**Figure 23** compares the combined Medicaid and MHA children served in inpatient and residential levels of care. This comparison shows that New Jersey uses inpatient services at a similar but somewhat higher rate than Maryland, at a higher rate than Massachusetts, but considerably lower than the counties of SE PA. There were only 2 comparison states for use of residential services, and New Jersey fell considerably lower than Pennsylvania, but was very similar to Maryland in 2004, falling below it in 2005.

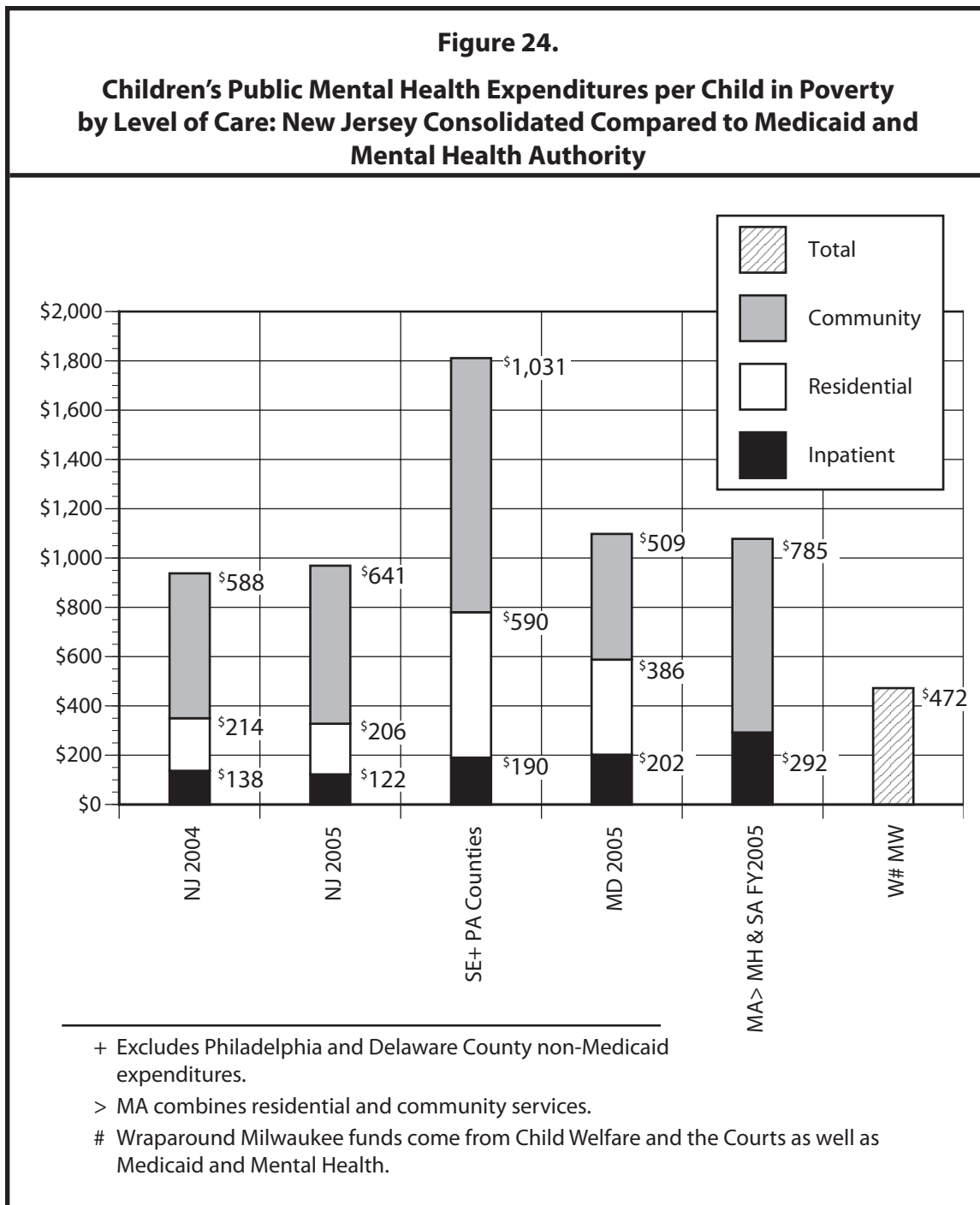


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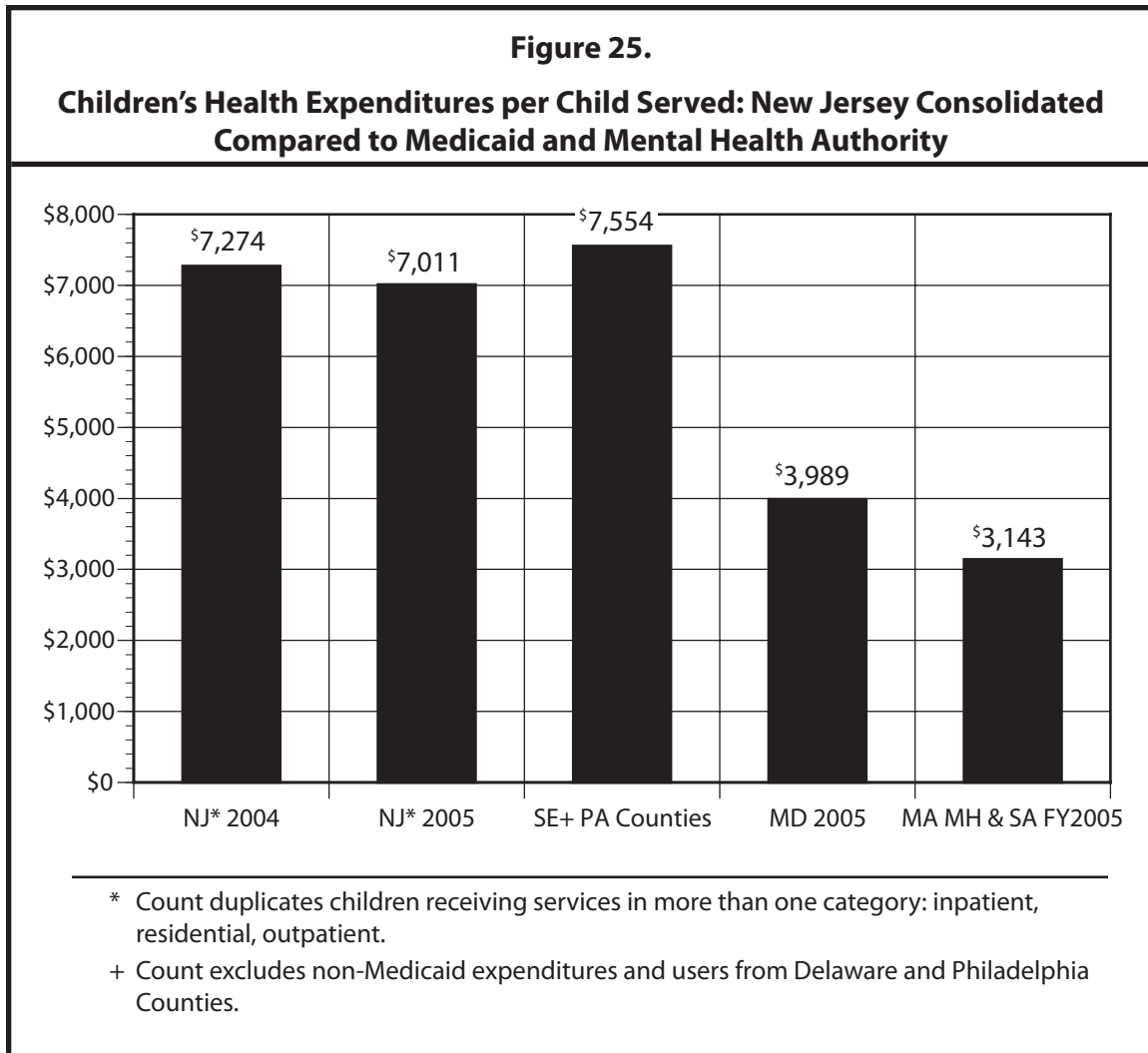
## Expenditures Rates

To take into account the number of children in poverty in the state or county, we can look at the rate of expenditure for children's combined Medicaid and Mental Health Authority mental health services per child in the state or county. However, it is important to note that, while our consolidated New Jersey expenditures exclude some non-Medicaid expenditures for counties in the process of implementing systems of care, they do include the contributions of the child welfare and juvenile justice agencies toward the cost of certain mental health services. As seen in **Figure 24**, New Jersey looks much more similar to the other entities in its rate of expenditure per child, with the exception of the SE PA counties whose level of expenditures far exceed the others. In this regard, New Jersey also compares favorably in its relative use of inpatient and residential services, with a somewhat lower share of its total expenditures going for inpatient and residential services. While the SE PA counties expend a greater amount per child on community and outpatient services than New Jersey, they appear to expend a greater proportion of their costs on inpatient and residential than New Jersey. It should be noted that some part of Pennsylvania's higher level of expenditure likely stems from their expansive enrollment of children with disabilities into Medicaid than other states, giving them a relatively higher need caseload, all other things equal.



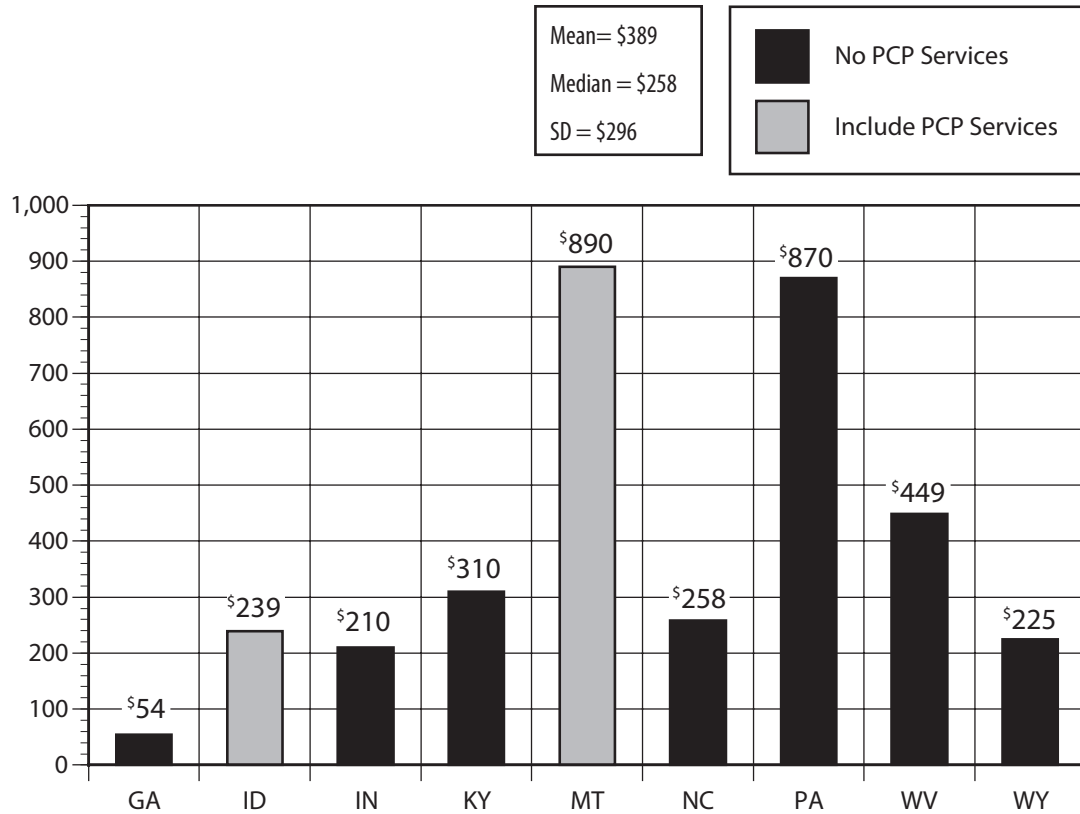


New Jersey's relatively low figures in children served and its similarities in rates and patterns of expenditures suggest that its average cost per child served may differ considerably from comparison entities. **Figure 25** shows this to be the case. New Jersey spends about the same per child receiving services as the SE PA counties, and much more than Maryland and Massachusetts. Per child expenditures for Wraparound Milwaukee (not shown on the chart) were much higher, above \$29,000 for its very high need group of children at risk for residential placement.



We compared New Jersey's cost of Medicaid services per Medicaid enrollee, which amounted to \$472 and \$462 in 2004 and 2005 respectively, to the Children's Mental Health Benchmarking data from an earlier period. New Jersey is above the mean and median of this larger group of states and counties, while Pennsylvania is a high outlier among this larger group of states as it has been in our smaller comparison group.

**Figure 26.**  
**Medicaid Expenditures per Enrollee**



**Footnotes for Figure 26. Medicaid Expenditures per Enrollee**

Idaho	Excludes any children receiving solely inpatient care.
Indiana	Includes children in any Medicaid residential facility that have a primary MH diagnosis, including those in ICF-MRs and the costs of those services.
Montana	Excludes residential program room and board costs of children in state custody.
North Carolina	Excludes residential program room and board costs of children in state custody.
Wyoming	Excludes costs and clients served solely at state hospitals. Includes services provided by mental health practitioners billing under a physician's provider number.

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## Conclusion

New Jersey has significantly increased its rate of Medicaid and Non-Medicaid expenditures for children's mental health from the time of our original study. In the intervening years, the allocation of resources between the counties has come to more closely correspond to the degree of need.

More recently, we see that New Jersey reached 6% more youth and young adults in 2005 than in the prior year, while increasing expenditures at the more moderate rate of 3%. The penetration rate increase exceeded the growth of children in the population, and more than kept up with the growth of 5% experienced by the Medicaid child population. Notably, one eligibility group, DCF children, a highly vulnerable group, experienced a decrease of 8% in penetration that warrants further investigation, though its penetration remains very high. The most recent Census poverty estimates showed considerable growth, 15%, between 2002 and 2003. Thus it is possible that New Jersey's 5% growth in Medicaid enrollment may not be keeping pace with the growth of children in poverty, making it harder for unenrolled poor children in need of services to access them.

Despite the significant growth in New Jersey's public mental health system, it appears to be far from serving the number of children in the state likely to be experiencing either a mild, significant or extreme impairment from a mental health problem. The proportionally least served groups are those with more significant needs. Comparisons to other states and counties show that New Jersey's penetration rate is relatively low and indicates that there is room for improvement.

New Jersey has been able to self-finance a portion of its service expansion through shifts from inpatient and residential services to spending on community services. These changes are consistent with the principles of systems of care, and county by county analysis suggests that these changes have been influenced by the implementation of systems of care. The funds for this expansion of use of mental health services come predominantly from Medicaid, which covers about 83% of the expenditures funneled through the consolidated payment process. State funded services have also grown, but we did not have the data needed to account for it.

Cross state comparisons show that New Jersey's expenditures are similar to many other states on a population basis, but they stand out as high in average costs per child served. Relatively high expenditure levels may be in part explained by New Jersey's inclusion of child welfare and juvenile justice funds paid through its consolidated system, where, except for Wraparound Milwaukee, other service systems included only Medicaid and mental health authority funds. However, New Jersey's pattern of high average expenditures per child at all levels of care, combined with the possibility of relatively low penetration rates, suggests that it tends to provide an intensive level of service to the children it reaches.

As would be expected in a state where counties are in so many different phases of implementing a fundamental transformation in provision of services, there is considerable variation in their provision of the new and conventional services. Clearly, there is a strong element of time for implementation and maturation affecting this variation. There are other

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likely sources of variation due to differences in reporting, such as quality of implementation, differing capacity in local service systems, and possibly, differences in how cases are classified as active and counted.

## Recommendations

This analysis is of necessity, preliminary, and must be regarded as a starting place for identifying access, cost and utilization issues needing further investigation. However, this analysis does suggest the areas that should receiving priority for further investigation.

New Jersey should provide ample resources to account for, track and monitor its behavioral health expenditures going forward. Given the likelihood that New Jersey is spending at levels that are similar to other states, while serving fewer children, it is critical to collect the additional data needed to confirm that this is an accurate conclusion. As of 2006, all counties will have implemented systems of care to the point that they will have begun billing their services through the consolidated system operated by the Medicaid vendor. At that point the Medicaid agency will be able to produce data that can be described as total Medicaid and non-Medicaid services for all counties. The state should work with the Medicaid agency to develop some standard reports and the capacity for further analysis. In addition, DCBHS needs to develop methods to account for any services provided outside of this consolidated system, if any.

New Jersey appears to have made significant progress in allocating resources in accordance with children's needs. However, the simple index we constructed may not be the best measure for the purpose of tracking performance and guiding improvement. New Jersey should develop a robust and useful need indicator and track it over time. In our initial study, Dr. Leonard Feldman, then Director of Research for the NJ Department of Human Services, constructed a more sophisticated psychometric index that better equalized the influence of the different measures. This may be a resource for future work.

New Jersey's implementation of systems of care appears to have reduced the number of children using residential care and reduced variation in the rates of utilization of residential services in the counties that have implemented it, perhaps in part by using shorter inpatient admissions as an alternative. However, it has not significantly reduced the average cost for children in residential care, suggesting that the lengths of stay of those sent to residential have remained about the same. These trends are likely to continue as systems of care mature statewide. However, since New Jersey's cost per child served is quite high in comparison to other states, it should consider whether it can further reduce the use of these high cost levels of care.

These data show that not all counties have achieved the same results in their implementation of systems of care. The state should seek to understand the reasons for the high level of access in Burlington County. If this is due to performance rather than a difference in reporting (for example, keeping inactive cases on the active case list) the state should seek to determine how this is achieved and how it benefits children and families. Similarly, the

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state should investigate the reasons that Essex and Hudson Counties appear to lag behind the other Phase 2 implementers. Any lessons of relevance to other counties should be shared, and the Phase 3 counties, now in the early stages of full operations, should be monitored to identify potential problems.

As implementation proceeds and the system matures, New Jersey should expect to see less variation, and should seek to understand the reasons for variation that remains so that it can establish policies that support equivalent access to systems of care throughout the state and maintain the greater degree of correspondence between county needs and resources that it has achieved in the larger public behavioral health system for children. ■

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## References

- Anderson, R. L., Lyons, J. S., Giles, D. M., Price, J. A., & Estle, G. (2003). Reliability of the Child and Adolescent Needs and Strengths-Mental Health (CANS-MH) Scale. *Journal of Child and Family Studies*, 2(3), 279–289.
- Arizona Department of Health Services, Division of Behavioral Health Services, Network. (2006). ADHS/DBHS clinical guidance documents. Retrieved July, 2006, from <http://www.azdhs.gov/bhs/guidance/guidance.htm>
- Bruns, E. J., Suter, J. C., Force, M. M., & Burchard, J. D. (2005). Adherence to Wraparound principles and associations with outcomes. *Journal of Child and Family Studies*, 14(4), 521–534.
- Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review*, 2(4), 199–254.
- Calawan, J. (May 2005). *An update on New Jersey's statewide implementation of IMDS application*. Trenton, NJ: New Jersey Division of Child Behavioral Health Services (DCBHS). [Power Point Presentation].
- Center for Health Care Strategies. (2006). Media; Project Spotlight: ValueOptions New Jersey: Shortening Residential Care Stays for Teens. Retrieved September 19th, 2006, from [http://www.chcs.org/info-url3969/info-url\\_show.htm?doc\\_id=356610](http://www.chcs.org/info-url3969/info-url_show.htm?doc_id=356610)
- State of New Jersey, Department of Human Services (2000). Children's Initiative Concept Paper. Trenton, NJ.
- Choices, Inc. (2005). *Hamilton Choices Mosaic Project contract performance indicators report*. Indianapolis, IN: Choices, Inc. Available <https://www.choicesteam.org/content/choices/documents/re/HC%20Contract%20Performance%20Indicators%20June%202004%20Report.pdf>
- ValueOptions, New Jersey, Contracted Systems Administrator, Division of Child Behavioral Health Services. (2006, April). CSA Overview Presented to Louis del la Parte Florida Mental Health Institute, University of South Florida Independent Assessment Team Members, Tampa, FL.
- Daleiden, E.L. & Chorpita, B.F. (2005) From data to wisdom: Quality improvement strategies supporting large-scale implementation of evidence-based services. *Child and Adolescent Psychiatric Clinics of North America*, 14, 329–349.
- Daleiden, E. L. & Tolman, R. (2005). *State of Hawai'i, Department of Health, Child and Adolescent Mental Health Division: Annual Evaluation Report, Fiscal Year 2005*. Honolulu, HI: State Department of Health.
- Division of Child Behavioral Health Services. (2005). *Accomplishments for Contract Year IV ending September 2005* (Value Options, New Jersey Publication). Trenton, NJ.
- Dougherty Management Associates, Inc., (2005). Children's mental health benchmarking report: Year 4. Lexington, MA: The Associates. Available [http://www.chcs.org/usr\\_doc/MH\\_BenchmarkingYr4\\_Report.pdf](http://www.chcs.org/usr_doc/MH_BenchmarkingYr4_Report.pdf).



- 
- Drake, R.E., Merrens, M, R., Lynde, D.W. (2005). *Evidence-based mental health practice: A textbook*. New York, NY : W.W. Norton
- Evans, M. E. & Armstrong, M. I. (2002). What is case management? In B. J. Burns & K. Hoagwood (Eds.). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders* (pp. 39-68). New York, NY: Oxford University Press.
- Evans, M.E., Armstrong, M.I. & Newton-Lodgson, G. (2005) *Highlights: A study of the impact of policy on collaboration in system of care*. Tampa, FL: University of South Florida, the Louis de la Parte Florida Mental Health Institute (FMHI Publication #230).
- Farmer, E. M. Z., Dorsey, S., & Mustillo, S. A. (2004). Intensive home and community interventions. *Child and Adolescent Psychiatric Clinics of North America*, 13, 857–884.
- Feldman, N.D. ( no date) *The Brisbane report: A review of the care and treatment provided by New Jersey's Arthur Brisbane Child Treatment Center*. Trenton, NJ: New Jersey Protection and Advocacy, Inc. Retrieved 2006, from <http://www.njpanda.org/brisbane.html> [<http://www.njpanda.org/PT2.html>].
- Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI publication #231).
- Florida Department of Children and Family Services (2005) *DCF 3-tier integrated quality management system*. Tallahassee, FL.
- Friedman, R. M., Drews, D. A., Blase, K. A., Fixsen, D. L., Paulson, R. I., Zusman, J. (2005). Children's mental health: Service array, evidence-based practices and quality improvement. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute.
- Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R. W., & Sondheimer, D. L. (1996). Prevalence of serious emotional disturbance in children and adolescents. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental Health, United States, 1996* (pp. 71–89). Washington, DC: U.S. Government Printing Office .
- Friedman, R.M. (2006). *Improving the effectiveness of Medicaid funded children's mental health services*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute.
- Harvard University (2006) *Performance based contracting*. Retrieved July 19, 2006, from <http://www.innovations.harvard.edu/awards.html?id=3879>.
- Hawaii Child and Adolescent Mental Health Division (2005a) *Quality assurance and improvement program: October 2005-September 2006*. Retrieved July 18, 2006 from <http://www.hawaii.gov/health/mental-health/camhd/library/pdf/qaip-5.pdf>.
- Hawaii Child and Adolescent Mental Health Division (2005b) *Quality assurance and improvement program work plan: October 2005–September 2006*. Retrieved July 18, 2006 from <http://www.hawaii.gov/health/mental-health/camhd/library/pdf/qaip-6.pdf>.
- Hornberger, S., Martin, T., & Collins, J. (2006) *Integrating systems of care: Improving quality of care for the most vulnerable children and families*. Washington, DC: CWLA Press.

- 
- Institute of Medicine, Committee on Quality of Healthcare in America (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.
- Isaacs, M., Benjamin, M. et al. (1989–1998). *Towards a culturally competent system of care*. Washington, DC: Georgetown University Child Development Center. National Technical Assistance Center for Children's Mental Health.
- Koppelman, J. (2005). Mental health and juvenile justice: *Moving toward more effective systems of care*. *National Mental Health Policy Center Issue Brief*, 805(July 22), 1–24 . Washington, DC: National Health Policy Forum.
- Leon, S.C., Lyons, J.S., Uziel-Miller, N.D., & Tracy, P. (1999). Psychiatric hospital utilization of children and adolescents in state custody. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 305–310.
- Lezak, A. & Macbeth, G. (2001). Overcoming barriers to serving our children in the community: Making the Olmstead Decision work for children with mental health needs and their families. Delmar, NY: Advocates for Human Potential [Prepared under contract between The Gallup Organization and the Division of State and Community Systems Development (Mental Health Block Grant Branch)]. Available <http://www.olmsteadcommunity.org/documents/Barriers2.pdf>].
- Logosso, K. E. & Sabin, J. I. (2004). *Arthur Brisbane Child Treatment Center Investigation: an Examination of Conditions of Care and Recommendations for Reform*. Trenton, NJ: Office Of The Child Advocate. Available [http://www.childadvocate.nj.gov/downloads/brisbane\\_final\\_report.pdf](http://www.childadvocate.nj.gov/downloads/brisbane_final_report.pdf).
- Lyons, J. S. (January 2003). *The needs of children referred into CMOs within The New Jersey Children's Initiative: An analysis of selection characteristics*. Winnetka IL: Buddin Praed Foundation.
- Lyons, J. S. (May 2003). *Mobile response and stabilization system (MRSS): Initial report on the decision making and outcomes using the crisis assessment tool*. Retrieved 2006, from website: <http://Buddin-Praed.com>
- Lyons, J. S. (2004). *Redressing the emperor: Improving our children's public mental health system*. Westport, CT: Praeger.
- Lyons, J. S., Griffin, E., Fazio, M., & Lyons, M. B. (Revised 2003; c1999). *Child & adolescent needs & strengths: An information integration tool for children and adolescents with mental health challenges: CANS-MH manual*. Winnetka, IL: Buddin Praed Foundation.
- Lyons, J. S. , Kisiel, C. L., Dulcan, M., Cohen, R., Chesler, P. (1997). Crisis assessment and psychiatric hospitalization of children and adolescents in state custody. *Journal of Child and Family Studies*, 6, 311–320.
- Lyons, J. S., Mintzer, L. L., Kisiel, C. L., Shallcross, H. (1998). Understanding the mental health needs of children and adolescents in residential treatment. *Professional Psychology: Research and Practice*, 29, 582–587.

- 
- MacIntyre II, J.C., Essock, S., Clay, S., Zuber, M.P. & Felton, C.J. (2006), The Kids Oneida Project: What happened to services when the payment rules changed, *Administration & Policy in Mental Health & Mental Health Services Research*, 33(5), 585–597.
- Manderscheid, R.W. & Sonnenschein, M.A. (1996). *Mental health, United States, 1996* (DHHS Pub. No. (SMA) 96-3098). Washington D.C.: Superintendent of Documents, U.S. Government Printing Office.
- Manderscheid, R.W. & Sonnenschein, M.A., eds (1996). Methodology for Epidemiology of Mental Disorders in Children and Adolescents (MECA Study) noted in “The Surgeon General’s Report on Mental Health. U.S. Government Printing Office.
- Marics, C., Vaughan, E., Martin, M., and Vietze, A. (2005). *A proposed methodology for sizing New Jersey’s system of care*. Trenton, NJ: New Jersey Department of Human Services, Division of Child Behavioral Health Services
- Mattessich, P.W., Murray-Close, M., & Monsey, B.R. (2001). *Collaboration: What makes it work* (2nd ed.). St. Paul, MN: Amherst H. Wilder Foundation
- McDermott, R. (1999a). Knowledge management: Why information technology inspired but cannot deliver knowledge management. *California Management Review*, 41(4), 103–117.
- Minnesota Chemical and Mental Health Services Administration, Department of Human Services, <http://www.dhs.state.mn.us/main>
- New Jersey Department of Human Services. (2000, January). *System of care concept paper: A system of care for children with emotional and behavioral disturbances and their families*. Trenton, NJ: The Department
- New Jersey Department of Human Services, Division of Child Behavioral Health Services (2006). *Glossary of items for the information management decision support assessment tools*. Trenton, NJ: The Department.
- New Jersey Department of Human Services (2004). *A new beginning: The future of child welfare in New Jersey*. Trenton, NJ: The Department.
- New Jersey, Department of Human Services (2000). *Children’s Initiative Concept Paper*. Trenton, NJ. The Department.
- New Jersey, Division of Child Behavioral Health Services (2005). *2005–2006 quality assessment and performance improvement (QAPI): Program description*. Trenton, NJ: The Division.
- New Jersey, Division of Child Behavioral Health Services. (2005). *Accomplishments for contract Year IV ending September 2005* (Value Options). Trenton, NJ.
- New Jersey Division of Mental Health Services, New Jersey Division of Child Behavioral Health Services, New Jersey Community Mental Health Board, New Jersey Mental Health Planning Advisory Council (2004, September). *State of New Jersey, Community Mental Health Services Block Grant Application for Fiscal Years 2005–2007* Retrieved <http://www.state.nj.us/humanservices/dmhs/BLOCK-GRANT%20YRS%2005-07.pdf>.
- Nutt, P.C. (2002) *Why decisions fail*. San Francisco, CA: Barrett-Koehler Publishers, Inc.

- 
- O'Brien, M. & Watson, P. (2002, March). *A framework for quality assurance in child welfare*. Portland, ME: National Child Welfare Resource Center for Organizational Improvement, University of Southern Maine, Edmund S. Muskie School of Public Service. Available <http://muskie.usm.maine.edu/helpkids/rcpdfs/QA.pdf>.
- Pennsylvania Department of Public Welfare (July 14, 2004). *Behavioral HealthChoices*. Retrieved from [www.dpw.state.pa.us/Disable/MentalHealthServices/003670135.htm](http://www.dpw.state.pa.us/Disable/MentalHealthServices/003670135.htm).
- Pires, S. A. (2002). *Building systems of care: A primer*. National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, Washington, D.C.
- Pires, S.A. (2000). *Key issues for governing bodies*. Washington, D.C.: Human Services Collaborative.
- Pires, S. A., (2002). *Health care reform tracking project (HC RTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems, 1: Managed care design & financing* (FMHI publication #211-1). Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute
- Pires, S. A., & Grimes, K. E. (2006). *Health care reform tracking project (HC RTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems, 8: Clinical decision making approaches for child/adolescent behavioral health care in public sector managed care systems* (FMHI publication #211-8). Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute.
- Pires, S.A., Stroul, B. A., & Armstrong, M. I. (2001). *Health care reform tracking project Findings of the 2000 state survey* (FMHI publication #212-3) . Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute.
- Rauktis, M.B. and Hdalio, J. (2001). The validity of the Child and Adolescent Needs and Strengths. Paper presented at the 14th annual meeting of the Research and Training Center for Children's Mental Health, Tampa, FL.
- Rosenheck, R. A. (2001). Organizational process: A missing link between research and practice. *Psychiatric Services*, 52(12), 1607–1612.
- SAMHSA study of model programs and evidence-based programs and practices, 2005 (Mental Health Services Gap Project, Grant # 1-H79-SM56834-01).
- Shaffer, D., Fisher, P., Dulcan, M. K., Davies, M., Piacentini, J., Schwab-Stone, et al. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(7), 865–877.
- Stroul, B.A. (2002). *Issue brief Systems of care : A framework for system reform in children's mental health*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. Retrieved [http://gucchd.georgetown.edu/files/products\\_publications/SOCbrief.pdf](http://gucchd.georgetown.edu/files/products_publications/SOCbrief.pdf).

- 
- Stroul, B. A. (2006). Executive Summary: The Sustainability of Systems of Care: Lessons Learned. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Child, Adolescent and Family Branch: Report on the Special Study on the Sustainability of Systems of Care.
- Stroul, B. A., & Friedman, R. M. (1986). *A system of care for children and youth with severe emotional disturbances*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.
- Taub, J. & Breault, C. (2006, February). *Relationships between fidelity and outcomes in a multi-site Wraparound initiative*. Symposium presented at the 19th Annual Research Conference: A System of Care for Children's Mental Health: Expanding the Research Base, Tampa, FL.
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, Maryland: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- U.S. Department of Health and Human Services. Children's System of Care Grant Applications, Albany, New York; New York City, New York; Monroe County, New York; Kalamazoo, Michigan. Rockville, Maryland: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services
- Utah Division of Child and Family Services (1999). *The performance milestone plan*. Retrieved July 18, 2006 from <http://www.hsdccfs.state.ut.us/PDF/milestone.pdf>
- ValueOptions & State of New Jersey Division of Child Behavioral Health Services. (2006, April). CSA Overview.
- Winters, N., Collett, B., & Myers, K. (2005). Ten-year review of rating scales, VII: Scales assessing functional impairment. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44(4), 309–338. ■





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# Appendix A

## Focus Groups Probes

### CMO Directors

- 1) What does the governance structure at the county look like? Who is included? How does it operate?
- 2) How are services at the county level integrated among the CSA, CMO, YCM, Mobile Response, FSO, and the State? What about with child welfare, juvenile justice, etc?
- 3) Are there appropriate services for every level of need in the system? Are there services lacking in the service array that impact outcomes for children and families?
- 4) How has having two levels of case management impacted the system? Is it working?
- 5) How is child level assessment data collected and utilized? How is service/quality assurance data received and utilized?

### MRSS Directors

- 1) What does the governance structure at the county look like? Who is included? How does it operate?
- 2) How are services at the county level integrated among the CSA, CMO, YCM, Mobile Response, FSO and the State? What about with child welfare, juvenile justice, etc?
- 3) How does the MRSS collaborate with the CMO, YCM, and FSO? What about referrals and the VO triage process?
- 4) How is child level assessment data (or other data) utilized? How is service/quality assurance data received and utilized?

### YCM Program Supervisors

- 1) What does the governance structure at the county look like? Who is included? How does it operate?
- 2) How are services at the county level integrated among the CSA, CMO, YCM, Mobile Response, FSO, and the State? What about with child welfare, juvenile justice, etc?
- 3) Are there appropriate services for every level of need in the system? Are there services lacking in the service array that impact outcomes for children and families?
- 4) How has having two levels of case management impacted the system? Is it working?
- 5) How is child level assessment data collected and utilized?



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## **FSO Directors**

- 1) What does the governance structure at the county look like? Who is included? How does it operate?
- 2) How are services at the county level integrated among the CSA, CMO, YCM, Mobile Response, FSO and the State? What about with child welfare, juvenile justice, etc?
- 3) Are there appropriate services for every level of need in the system? Are there services lacking in the service array that impact outcomes for children and families?
- 4) How are families involved in service planning for their children?
- 5) How has having two levels of case management impacted the system? Is it working?

## **Team Leaders**

- 1) Please describe the integration between the state and the county CMO, FSO, MRSS, YCM and providers.
- 2) Please describe your role as the team leader. ■

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# Appendix B

## Internet Survey Questions (Condensed Version)

### General Survey Questions

#### Demographic

- 1) I have read the description of the study and I give my consent for participation in the survey. I understand that no identifying information will be shared beyond the research group at USF and that data reported will be aggregated at the state and/or county level.
- 2) I have read the above statements regarding Neutral and Don't Know answer choices.
- 3) Please choose the county or counties you represent. Check all that apply.
- 4) Please indicate your role below.

#### Quality Improvement and Assurance

- 1) Does your agency have a formal training program (i.e., training experiences sponsored by your organization) that is required for CQI staff?
- 2) Have you participated in such a training within the past 12 months?
- 3) If YES, have you found this training to be relevant and beneficial to your job responsibilities?
- 4) Do you collect and report outcome data for individual children?
- 5) If YES, is child level outcome data used by the agency for program improvement and/or used to inform decision-making?
- 6) If YES, please describe how below.
- 7) Do you routinely collect and report overall program data?
- 8) If YES, what reports or data do you receive regarding overall program data?
- 9) Is the overall program data regularly analyzed by the QI process to make program improvements?
- 10) If the overall program data is used for program improvement, please describe how below.
- 11) Do children and families have opportunities to provide information regarding their level of satisfaction with services they receive?
- 12) If satisfaction data is collected, is it regularly collected and analyzed for quality assurance and improvement purposes? By whom? How is this information collected (survey, interview, etc.)? Please describe below.

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- 13) Do you have opportunities to provide input into the CQI process?
  - 14) If YES, how? Please describe below.
  - 15) Have there been any barriers to the implementation of the CQI Plan? Please describe below.
  - 16) What have been facilitators to implementation of the CQI Plan? Please describe below.
  - 17) To your knowledge, has the CBHS Continuous Quality Improvement Plan been reviewed or modified within the past 12 months?
  - 18) If YES, have you had the opportunity to provide input into the plan?
  - 19) System Performance: Please review the system performance information below and answer the following:  
Column 1: Is the information tracked?  
Column 2: Is the information summarized and used for system planning?
  - 20) Is there any other information not included on the list above? Is that information tracked and/or used in system planning? Please describe below.

### **System of Care Philosophy, Values and Principles**

- 1) Are you familiar with the philosophy, values and principles of Systems of Care?
- 2) Please indicate your level of agreement with the following statement: System of Care is an appropriate model for meeting the behavioral health needs of children with the most serious and persistent problems.
- 3) Did you receive training on the philosophy, values and principles of Systems of Care?
- 4) If you DID receive training on Systems of Care, how was the training delivered? Check all that apply. (Choose "Not Applicable" if you did not receive training.)
- 5) If you DID receive training, please indicate your level of agreement with the following statement: The training was adequate for orientation and understanding of philosophy, values and principles of Systems of Care.
- 6) If you DID receive training, please indicate your level of agreement with the following statement: The training was adequate to help guide Systems of Care implementation efforts.
- 7) Would you like to receive more information and training regarding the philosophy, values, and principles of Systems of Care?
- 8) Please indicate your level of agreement with the statement below for each of the system partners listed: This system partner is committed to System of Care philosophy, values and principles.
- 9) Please list below system partners not included in the above list and whether or not you agree that the system partner is committed to the System of Care philosophy, values and principles.

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- 10) Please indicate your level of agreement with the following statement: The philosophy, values and principles of System of Care are reflected in decision-making as it relates to service provision (including policies, procedures, case/care management, etc.).
  - 11) Is there anything you would like to share with us regarding Systems of Care? If so, please explain in the box below.

## **Governance Structure**

- 1) For your community, please indicate:  
**Column 1:** If the following board, committee or council is currently involved in the children's behavioral health system.  
**Column 2:** Your level of agreement with the following statement:  
The board, committee, or council's mandates, goals and authority are clearly defined.
- 2) Please list below any boards, councils, and/or committees in your community that are not included in the list above.
- 3) Please indicate your level of agreement with the following statements about the boards, committees, and councils in your community:
- 4) Are there any system partners, organizations, or stakeholders not represented by the boards, councils and committees that influence the System of Care?
- 5) If YES, who/what is not represented? What is the impact on service delivery?
- 6) Are there any system partners, organizations, or stakeholders that are over represented on the boards, councils and committees?
- 7) If YES, who/what is over represented? What is the impact on service delivery?
- 8) In your community, which board, council or committee has the most influence on the community System of Care?
- 9) Why? What type of influence? Is it a positive or negative influence? Please explain below.
- 10) Thinking of the board, council or committee in your community with the most influence on System of Care, does the DCBHS have a procedure for responding to the recommendations made by that entity?
- 11) If YES to #10, is that procedure and/or method effective?
- 12) When recommendations are made to DCBHS from your county boards, councils or committees, do you see change take place in your community?
- 13) If changes DO occur in your community, do they occur in a timely manner?
- 14) Does the DCBHS request information from the county boards, councils and committees for decision-making and planning at the state level?

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- 15) Please indicate your level of agreement with the following statement: Our current Team Leader's role as a liaison between the DCBHS and our community is beneficial to our System of Care.
  - 16) Please indicate below the role(s) the Team Leader has played in your community AND if that is an appropriate role for the Team Leader.
  - 17) Please indicate your level of agreement with the following statement: I am comfortable sharing information with our Team Leader.
  - 18) Is there anything else you would like to share about the governance structure or day-to-day operations in your community? Please describe below.

### **Service Access and Availability**

- 1) Please review the programs and services below and indicate those that currently exist in your community. Please check all that apply.
- 2) Please indicate your level of agreement with the following statement: The array of services in my community is adequate for meeting the needs of children and families.
- 3) Regarding any gaps in the service array, what services need to be added to the service array in your community to improve children's mental health services? (e.g., specific populations, presenting problems, diagnoses, service locations).
- 4) When access to service(s) is problematic (e.g., wait list that are too long, services do not exist or lengths of stay or service is inappropriately short or long), indicate which, if any, of the following system issues have typically occurred in your community. Check all that apply.
- 5) Please list below the three services with the most problematic access issues.
- 6) Aside from needing a particular service, do the children wait listed for services have any characteristics in common? (e.g., non-Medicaid receiving, specific age range, gender)
- 7) If children on wait lists DO have common characteristics, please describe in the space below.
- 8) Please indicate your level of agreement with the following statement: Services are used efficiently (e.g., residential beds, providers operate at capacity).
- 9) If NOT, which services are not being used efficiently?
- 10) How well do the descriptions of services provided by agencies match actual services that are available?
- 11) Please explain your response to question #10 below.
- 12) Are there any specific population(s) of children providers are reluctant to serve and/or specific populations that providers will serve first (before another population)? Please explain below.

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- 13) Please indicate your level of agreement with the following statement: Policies and procedures from the DCBHS support the creation and expansion of an accessible and appropriate service array in my community.
  - 14) Please indicate your level of agreement with the following statement: Continuity of care (e.g., consistent care/case manager, smooth transitions) is maintained for children/youth being served by the System of Care in my community.
  - 15) Please indicate your level of agreement with the following statement: Families request service(s) that are not available in my community.
  - 16) If you Strongly Agree or Agree with #15, what services are requested that are not available?
  - 17) Please indicate your level of agreement with the following statement: Acknowledgement of cultural and language diversity is reflected in the service delivery process.
  - 18) What is the average length of time between a child entering the Absolut data system and receiving services at your organization?

### **Collaboration and Integration**

- 1) Please indicate your level of agreement for the following statements regarding the integration of work among system partners:
- 2) How do you receive information regarding DCBHS policies and procedures?
- 3) Indicate below how well the CMO and the following organizations/partners collaborate:
- 4) Indicate below how well the YCM and the following organizations/partners collaborate:
- 5) Indicate below how well the MRSS and the following organizations/partners collaborate:
- 6) Indicate below how well the FSO and the following organizations/partners collaborate:
- 7) Overall, does collaboration occur most often in a formal (through meetings, policies etc.) or informal manner (via emails, conversations etc.)? Please describe below.
- 8) Please indicate your level of agreement with the statements below concerning overall system partner collaboration in your community:
- 9) Have system partners engaged in joint trainings on topics related to system of care, collaboration, evidence-based practices, etc.?
- 10) If YES, please provide a listing of the types of joint trainings that have been offered.
- 11) If you have attended a joint training, how satisfied were you with the training?

- 
- 12) What facilitates integration and collaboration among system partners? Please describe below.
  - 13) What, if any, are barriers to integration and collaboration among system partners? Please describe below.

### **Use of Evidence- Based Practices and Programs**

- 1) Please list below any evidence-based practices and programs included in the service array in your community.
- 2) Have you received training to provide or to be made aware of any specific evidence-based practices or programs?
- 3) If YES, please describe.
- 4) Has there been support or interest in evidence-based practices and programs in your organization?
- 5) Do you feel there is interest in your community regarding evidence-based practices and programs?
- 6) What are the barriers and facilitators for implementing evidence-based practices and programs?

### **Data**

- 1) Please indicate below which, if any, of the following assessments (data) are utilized by your agency. Check all that apply.
- 2) Please describe any training that you, or your agency, have received in the use of these assessments.
- 3) Please indicate your level of agreement with the following statement: Case-specific consultation on the use of these assessments is available to me/my agency.
- 4) If case-specific consultation is available, who provides that consultation?
- 5) What additional assessment training do you feel you and/or your staff need?
- 6) Please indicate your level of agreement with the following statements regarding assessments:
- 7) Please indicate your level of agreement with the following statements regarding the use of data and data systems:
- 8) What are the strengths of the current data systems?
- 9) What needs to be done to improve the current data systems?

### **Referrals and Care Management (CMO)**

- 1) Please indicate your level of agreement with the following statements:
- 2) Please indicate below the contracted number of cases a Care Manager should carry and the actual number of cases carried.



- 
- 3) How often does the referral and transition process from the CMO to the YCM (step-down in services) occur in a smooth and timely manner?
  - 4) How often does the referral and transition process from the YCM to the CMO (step up in services) occur in a smooth and timely manner?
  - 5) Please indicate your level of agreement with the following statements:
  - 6) On average, what is the maximum amount of time a child receives services through your organization?
  - 7) Does the maximum length of service match with policies regarding how long children should receive services? Please explain below.
  - 8) Please indicate your level of agreement with the following statement: Overall, the Care Management process effectively links children and families to services for positive outcomes.

### **Referrals and Youth Case Management (YCM)**

- 1) Please indicate your level of agreement with the following statements:
- 2) Please indicate below the contracted number of cases a Youth Care Manager should carry and the actual number of cases carried.
- 3) How often does the referral and transition process from the CMO to the YCM (step-down in services) occur in a smooth and timely manner?
- 4) How often does the referral and transition process from the YCM to the CMO (step up in services) occur in a smooth and timely manner?
- 5) Please indicate your level of agreement with the following statements:
- 6) On average, what is the maximum amount of time a child receives services through your organization?
- 7) Does the maximum length of service match with policies regarding how long children should receive services? Please explain below.
- 8) Please indicate your level of agreement with the following statement: Overall, the Case Management process effectively links children and families to services for positive outcomes.

### **Recommendations to DCBHS**

- 1) What are the top three things the DCBHS can do to improve the children's behavioral health service system?
- 2) What are the top three things your agency can do to improve service delivery for children in the behavioral health system?
- 3) What are (up to) three things that should NOT be done in an effort to improve the children's behavioral health system?
- 4) Any other comments?

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# **DYFS Supervisors of Case Management Supervisors Survey**

## **Demographics**

- 1) Please choose the county or counties you represent. Check all that apply.

## **System of Care Philosophy and Values**

- 1) Are you familiar with the philosophy, values and principles of Systems of Care?
- 2) Please indicate your level of agreement with the following statement: System of Care is an appropriate model for meeting the behavioral health needs of children with the most serious and persistent problems.
- 3) Did you receive training on the philosophy, values and principles of Systems of Care?
- 4) If you DID receive training on Systems of Care, how was the training delivered? Check all that apply. (Choose "Not Applicable" if you did not receive training.)
- 5) If you DID receive training, please indicate your level of agreement with the following statement: The training was adequate for orientation and understanding of philosophy, values and principles of Systems of Care.
- 6) If you DID receive training, please indicate your level of agreement with the following statement: The training was adequate to help guide Systems of Care implementation efforts.
- 7) Would you like to receive more information and training regarding the philosophy, values, and principles of Systems of Care?
- 8) Please indicate your level of agreement with the statement below for each of the system partners listed: This system partner is committed to System of Care philosophy, values and principles.
- 9) Please list below system partners not included in the above list and whether or not you agree that the system partner is committed to the System of Care philosophy, values and principles.
- 10) Please indicate your level of agreement with the following statement:  
The philosophy, values and principles of System of Care are reflected in decision-making as it relates to service provision (including policies, procedures, case/care management, etc.).
- 11) Is there anything you would like to share with us regarding Systems of Care? If so, please explain in the box below.

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## Collaboration and Integration

- 1) Please indicate your level of agreement for the following statements regarding the integration of work among system partners:
- 2) How do you receive information regarding DCBHS policies and procedures?
- 3) Overall, does collaboration occur most often in a formal (through meetings, policies etc.) or informal manner (via emails, conversations etc.)? Please describe below.
- 4) Please indicate your level of agreement with the statements below concerning overall system partner collaboration in your community:
- 5) Have system partners engaged in joint trainings on topics related to system of care, collaboration, evidence-based practices, etc.?
- 6) If YES, please provide a listing of the types of joint trainings that have been offered.
- 7) If you have attended a joint training, how satisfied were you with the training?
- 8) What facilitates integration and collaboration among system partners? Please describe below.
- 9) What, if any, are barriers to integration and collaboration among system partners? Please describe below.

## Perspectives

- 1) Please comment on the strengths and benefits of the current child behavioral health system in meeting the mental health needs of the children you represent.
- 2) From your perspective, how effectively does the current Children's Behavioral Health Service System approach (e.g., System of Care) meet the needs of children and youth with the most severe behavioral health needs?
- 3) Please indicate your level of agreement with the following statement: Children being served in the child welfare system have access to appropriate behavioral health services.
- 4) Please explain your response to question #3 in the box below.
- 5) Please indicate your level of agreement with the following statement: Transitions between levels of care (CMO, YCM, MRSS) occur in a smooth and timely fashion among system partners.
- 6) Please explain your response to question #5 in the box below.
- 7) What are the top three things that need to be done at the county or state level to improve services for children and adolescents who have behavioral health (mental health) needs?
- 8) What are (up to) three things that should NOT be done in an effort to improve the children's behavioral health system?
- 9) Other comments?

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## Juvenile Justice and Law Guardian Attorney Survey

### Demographics

- 1) Please choose the county or counties you represent. Check all that apply.
- 2) Please indicate your role:

### System of Care Philosophy and Values

- 1) Are you familiar with the philosophy, values and principles of Systems of Care?
- 2) Please indicate your level of agreement with the following statement: System of Care is an appropriate model for meeting the behavioral health needs of children with the most serious and persistent problems.
- 3) Did you receive training on the philosophy, values and principles of Systems of Care?
- 4) If you DID receive training on Systems of Care, how was the training delivered? Check all that apply. (Choose "Not Applicable" if you did not receive training.)
- 5) If you DID receive training, please indicate your level of agreement with the following statement: The training was adequate for orientation and understanding of philosophy, values and principles of Systems of Care.
- 6) If you DID receive training, please indicate your level of agreement with the following statement: The training was adequate to help guide Systems of Care implementation efforts.
- 7) Would you like to receive more information and training regarding the philosophy, values, and principles of Systems of Care?
- 8) Please indicate your level of agreement with the statement below for each of the system partners listed: This system partner is committed to System of Care philosophy, values and principles.
- 9) Please list below system partners not included in the above list and whether or not you agree that the system partner is committed to the System of Care philosophy, values and principles.
- 10) Please indicate your level of agreement with the following statement:  
The philosophy, values and principles of System of Care are reflected in decision-making as it relates to service provision (including policies, procedures, case/care management, etc.).
- 11) Is there anything you would like to share with us regarding Systems of Care? If so, please explain in the box below.

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## Perspectives

- 1) Please comment on the strengths and benefits of the current child behavioral health system in meeting the mental health needs of the children you represent.
- 2) From your perspective, how effectively does the current Children's Behavioral Health Service System approach (e.g., System of Care) meet the needs of children and youth with the most severe behavioral health needs?
- 3) How do the access, availability and quality of mental health services for children and adolescents impact your work on their behalf?
- 4) How integrated are Child Welfare and Juvenile Justice with the Department of Children's Behavioral Health in meeting the needs of children and youth who are involved in multiple systems?
- 5) If you were an attorney both before and after the System of Care approach was adopted in your county/counties, how would you compare the past service system to services provided under a System of Care framework?
- 6) I am aware of Systems of Care and was involved before and after its implementation and can offer the following comments:
- 7) What needs to be done at the county or state level to improve services for children and adolescents who have behavioral health (mental health) needs?
- 8) Other comments? ■

# Appendix C

## Interviewee Matrix

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Interview - In Person or Telephone
3/29/2006	Personal interview	Euphemia Strauchn	Director, Keeping Families Together in New York City, New York City's System of Care Project, New York, New York	Beth Caldwell	Comparison State	In-Person
4/10/2006	Individual Interview	Patricia Bott	NYS OMH CAIRS Coordinator	Anne Kuppinger	Comparison State	In Person
4/17/2006	Individual Interview	Marcia Fazio	NYS OMH Deputy Direction Division of Children and Families	Anne Kuppinger	Comparison State	Telephone
4/27/2006	Individual Interview	Allison Campbell	NYS OMH Statewide SPOA Coord.	Anne Kuppinger	Comparison State	Telephone
5/3/2006	Individual Interview	Kimberly Britanak	UMDNJ IMDS Tools Lead Trainer	Anne Kuppinger		Telephone
5/10/2006	Individual Interview	Maddie Zivian	NYS OMH New York Regional Office	Anne Kuppinger	Comparison State	Telephone
5/11/2006	Individual Interview	Bill Barry	Chair, QAPI	Don Policella		In Person

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Telephone Interview - In Person or
5/11/2006	focus group 6 participants		YCM group 1	Karen Blasé		In Person
5/11/2006	focus group 7participants		YCM group 2	Frances Wallace		In Person
5/11/2006	focus group 7 participants		CM0 group 1	Karen Blasé		In Person
5/11/2006	focus groups 7 participants		CM0 group 2	Frances Wallace		In Person
5/12/2006	Individual Interview	Bill O'Brien	Interim Dir, Policy QA	Don Policella		In Person
5/12/2006	Individual Interview	Antoinette Gurden	CQI Spec	Don Policella		In Person
5/12/2006	Individual Interview	Anupa Varghese	CQI Spec	Don Policella		In Person
5/12/2006	Individual Interview			Don Policella		In Person



Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Interview - In Person or Telephone
5/18/2006	Focus groups			Frances Wallace		In Person
5/18/2006	Individual Interview	Sandra Rubin	Area Director	Don Policella		In Person
5/18/2006	focus group 7 participants		MRSS group 1	Frances Wallace		In Person
5/18/2006	focus groups 6 participants		MRSS group 2	Anne Kuppinger		In Person
5/18/2006	focus group 10- 12 participants		FSO	Frances W., Carol O		In Person
5/18/2006	Individual Interview	Connie Thomas	DCBHS Policy	Wendy Holt		In Person
5/18/2006	Focus group 10 participants		Team Leaders	Don Policella., Frances W. and Anne K.		In Person
5/19/2006	Individual Interview	Angelo McClain	Executive Director,VO	Beth Caldwell		In Person

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Telephone Interview - In Person or
5/19/2006	Individual Interview	Eleanor Vaughn	Director/ Clinical Operations, VO	Anne K., Beth C. and Don Policella.		In Person
5/19/2006	Individual Interview	Chris Marics	DCBHS Liaison	Anne K., Beth C.		In Person
5/19/2006	Individual Interview	Peggy McHale	Area Director, VO	Don Policella		In Person
5/19/2006	Individual Interview	Angelo McClain	Executive Director, VO	Don Policella, Anne K.		In Person
5/19/2006	Individual Interview	Donald Garafalo	IT Director, VO	Don Policella		In Person
5/19/2006	Individual Interview	Ed Martin	QA Director, VO	Don Policella		In Person
5/19/2006	Group Interview	Steve Adams, Phillip Frigerio	DCBHS CFO, Contract Mgr.	Wendy Holt		In Person

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Telephone Interview - In Person or
5/19/2006	Individual Interview	Edward Martin	Dir of Quality Mgmt., VO	Wendy Holt		In Person
5/19/2006	Individual Interview	Eleanor Vaughn	Clinical Director, VO	Don Policella		In Person
5/20/2006	Individual Interview	Madeline Lozowski	FSO Westfield, Union County	Beth Caldwell		In Person
5/20/2006	Individual Interview	William Wander	Implementation Mgr.	Beth Caldwell		In Person
5/23/2006	Individual Interview	Allan Vietze	Judiciary Liaison DCBHS	Beth Caldwell		In Person
5/26/2006	Individual interview	Angelo Mclean	Exec Dir VO	Wendy Holt		In Person
5/26/2006	Individual Interview	Edward Vacarro	Assistant Director DURB, NJ Medicaid	Wendy Holt		In Person
5/30/2006	Individual Interview	Barbara Chayt	Director, Interagency Services, JJC	Beth Caldwell		In Person

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Interview - In Person or Telephone
5/30/2006	Individual Interview	Marilyn Corradetti	Supervisor, Team leaders, DCBHS	Beth Caldwell		In Person
5/30/2006	Individual Interview	Kathy Enerlich	Deputy Director, DCBHS	Beth Caldwell		In Person
5/31/2006	Individual Interview	Andrea Van Dyke	Liaison to DCBHS, DYFS	Beth Caldwell		In Person
5/31/2006	Group Interview	Carol Grant, Julie Caliwan Kathleen Cassidy	Director, Developmental Disabilities	Beth Caldwell		In Person
6/1/2006	Individual Interview	Gianne Christiano	Bureau of Citizen's Complaints	Beth Caldwell		In Person
6/1/2006	Individual Interview	Marilyn Corradetti (2nd interview)	Supervisor, Team leaders, DCBHS	Beth Caldwell		In Person

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Interview - In Person or Telephone
6/8/2006	Individual Interview	John Lyons	CANS Author	Anne Kuppinger		Telephone
6/5/2006	Individual Interview	Suzanne Button	Director of Program Improvement	Anne Kuppinger	Comparison State	Telephone
6/15/06	Individual Interview	Bruce Kamradt	Director, Wraparound Milwaukee, Wisconsin	Beth Caldwell	Comparison State	In person
6/19/2006	individual Interview	MC07	YCM	Gregory Marshall	DCBHS	In Person
6/19/2006	Individual Interview	MC04	Grandmother	Rene` Anderson	DCBHS	In Person
6/19/2006	Individual Interview	MC01	Mother	Rene` Anderson	DCBHS	In Person
6/19/2006	Individual Interview	OC03	Mother	Rhonda Ort	DCBHS	In Person
6/19/2006	Individual Interview	OC02	Mother	Rhonda Ort	DCBHS	In Person

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Interview - In Person or Telephone
6/19/2006	Individual Interview	OC07	DYFS Guardian	Minnie Norton	DCBHS	In Person
6/19/2006	Individual Interview	OC04	Mother	Rhonda Ort	DCBHS	In Person
6/19/2006	Individual Interview	OC06	DYFS Guardian	Minnie Norton	DCBHS	In Person
6/20/2006	Individual interview	MC07(B)	Mother	Gregory Marshall	DCBHS	In Person
6/20/2006	Individual Interview	OC08	YCM	Minnie Norton	DCBHS	In Person
6/20/2006	Individual Interview	MC08	young adult	Rene` Anderson	DCBHS	In Person
6/20/2006	Individual Interview	MC10	grandmother	Rene` Anderson	DCBHS	In Person
6/20/2006	Individual Interview	MC04	CM0	Rene` Anderson	DCBHS	Telephone

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Telephone Interview - In Person or
6/20/2006	Individual Interview	MC10	CM0	Rene` Anderson	DCBHS	In Person
6/20/2006	Individual Interview	MC01	CM0	Rene` Anderson	DCBHS	In Person
6/20/2006	Individual Interview	OC05(B)	Mother	Minnie Norton	DCBHS	In Person
6/20/2006	Group Interview	MC06	DYFS Guardian	Gregory Marshall	DCBHS	In Person
6/20/2006	Individual Interview	OC10	Mother	Rhonda Ort	DCBHS	In Person
6/21/2006	Individual Interview	MC08	YCM	Rene` Anderson	DCBHS	Telephone
6/21/2006	Individual Interview	OC01	CM0	Rhonda Ort	DCBHS	In Person
6/21/2006	Individual Interview	OC06	CM0	Minnie Norton	DCBHS	In Person



Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	DCBHS or Community Interview request-	Telephone Interview - In Person or
6/21/2006	Individual Interview	OC07	CMO	Minnie Norton	DCBHS	In Person
6/21/2006	Individual Interview	MC09	YCM	Gregory Marshall	DCBHS	In Person
6/21/2006	Individual Interview	MC08	YCM	Rene` Anderson	DCBHS	Telephone
6/21/2006	Group Interview	Sharon Lindsay, Kim Britanak, Sue Furrer	UBHC,BRTI,CBHS, UMDNJ	Anne K., Beth C.	DCBHS	In Person
6/21/2006	Individual Interview	Eleanor Vaughan	Clinical Director, Value Options	Anne Kuppinger	DCBHS	Phone
6/21/2006	Individual Interview	Julie Cashen	Deputy Policy Director	Beth Caldwell	DCBHS	In Person
6/22/2006	Individual Interview	Jim Smith	Acting Director, Addiction Services	Beth Caldwell		In Person

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Interview - In Person or Telephone
6/22/2006	Individual Interview	Nadi Robinson	Director, Clinical Services, DCBHS	Beth Caldwell		In Person
6/22/2006	Group Interview	Debra Wentz / NJAMA Staff / Board Members	CEO, NJ Association Mental Health Agencies	Beth Caldwell		In Person
6/22/2006	Individual Interview	MC06	Dyfus Guardian	Gregory Marshall	DCBHS	In Person
6/22/2006	Individual Interview	MC03	CMO	Gregory Marshall	DCBHS	In Person
6/22/2006	Individual Interview	Kevin Martone	Director , Mental Health Services	Beth Caldwell		In Person
6/23/2006	Group Interview	Leonor Saenz , Luis Rivera	Mother/Child	Gregory Marshall	DCBHS	In Person

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Telephone Interview - In Person or
6/23/2006	Individual Interview	MC11	Father	Gregory Marshall	DCBHS	In Person
6/23/2006	Individual Interview	OC03	YCM	Rhonda Ort	DCBHS	In Person
6/23/2006	Individual Interview	OC10	YCM	Rhonda Ort	DCBHS	In Person
6/23/2006	Focus group 7 participants		NJACRTF- residential	Karen Blasé	DCBHS	Telephone
6/26/2006	Focus group 10 participants		Judiciary	Karen Blasé	DCBHS	Telephone
6/28/2006	Individual Interview	OC09	CMO-Rodriguez	Minnie Norton	DCBHS	In Person
6/26/2006	individual interview	Coutney Doerge	CMO	Rhonda Ort	DCBHS	Telephone

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Interview - In Person or Telephone
6/26/2006	Group Interview	Marcia Robinson Lowry, Susan Lambiase	Directors, Children's Right , Inc.	Beth Caldwell		In Person
6/26/2006	Individual Interview	Hetty Rosenstein	President, Local 1037Communication Workers	Beth Caldwell		In Person
6/27/2006	Individual Interview	Bruce Stout	Director, DCBHS	Beth Caldwell		In Person
6/27/2006	Individual Interview	Val Cassey	Supervisor. Residential Placement	Beth Caldwell		In Person
6/27/2006	Individual Interview	Jennifer Bak	Administrative Analyst	Beth Caldwell		In Person
6/27/2006	Focus group 10 participants		CMHA	Karen Blasé	DCBHS	Telephone
6/27/2006	Individual Interview	Eileen Crummy	Director, Youth & Family Services	Beth Caldwell		In Person

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Telephone Interview - In Person or
6/28/2006	Individual Interview	Robert Johnson	Dean, NJ Medical School	Beth Caldwell		Telephone
6/28/2006	Individual Interview	OC09	CMO	Minnie Norton	DCBHS	Telephone
6/29/2006	Individual Interview	Mary Coogan	Assistant Director, Association for Children of NJ	Beth Caldwell		Telephone
6/30/2006	Individual Interview	Cecilia Zaklind	Executive Director, Association for Children of NJ	Beth Caldwell		Telephone
6/30/2006	Individual Interview	Steve Cohen	Sr. Associate-Annie E. Casey Foundation	Beth Caldwell		Telephone
6/30/2006	Group Interview	Jean Wilkerson	Director, Quality Assurance(QSR))	Don P., Carol O.		Telephone
7/24/2006	Individual Interview	UC01	DYFS Guardian	Carol Obrochta	DCBHS	In Person
7/24/2006	Individual Interview	UC02	Mother	Carol Obrochta	DCBHS	In Person

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Telephone Interview - In Person or
7/25/2006	Individual Interview	UC03	Mother/Son	Carol O., Gregory M.	DCBHS	In Person
7/25/2006	Individual interview	UC06	DVFS Guardian	Gregory Marshall	DCBHS	In Person
7/26/2006	Individual interview	UC08	Mother	Gregory Marshall	DCBHS	In Person
7/26/2006	Individual interview	UC09	Aunt/Guardian	Gregory Marshall	DCBHS	In Person
7/26/2006	Individual Interview	UC05	Mother	Carol Obrochta	DCBHS	In Person
7/26/2006	Individual Interview	UC04	Legal Guardian	Carol Obrochta	DCBHS	In Person
7/26/2006	Individual Interview	UC01	CM0	Carol Obrochta	DCBHS	In Person
7/26/2006	Individual Interview	UC02	CM0	Carol Obrochta	DCBHS	In Person

Table C1. Interviewee Matrix						
Date of Contact	Type of Contact (Individual Interview / Focus Group/Child Family Review)	Name of Interviewee (Individual Interview only)	Title of Interviewee	USF Facilitator	Interview request- DCBHS or Community	Interview - In Person or Telephone
7/26/2006	Individual Interview	UC03	CM0	Carol Obrochta	DCBHS	In Person
7/26/2006	Individual Interview	Matthew Schiff	Medical Director, Value Options	Anne Kuppinger	DCBHS	Telephone
7/27/2006	Individual Interview	UC04	CM0	Carol Obrochta	DCBHS	In Person
7/27/2006	Individual Interview	UC05	CM0	Carol Obrochta	DCBHS	In Person
7/27/2006	Individual interview	UC10	Mother	Gregory Marshall	DCBHS	In Person
7/27/2006	Personal Interview	C.J. Johnson	Regional Administrator, Region V, Nebraska Department of Health and Human Services, Division of Behavioral Health	Beth Caldwell	Comparison State	In Person
7/28/2006	Individual interview	UC06	YCM	Gregory Marshall	DCBHS	In Person



Table C1. Interviewee Matrix						
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7/28/2006	Individual interview	UC07	YCM	Gregory Marshall	DCBHS	In Person
7/28/2006	Individual Interview	UC09	YCM	Gregory Marshall	DCBHS	In Person
7/28/2006	Individual Interview	UC10	YCM	Gregory Marshall	DCBHS	In Person
8/10/2006	Personal Interview	Beth Armstrong	MHMR Program Administrator, Kentucky Division of Mental Health and Substance Abuse Services	Beth Caldwell	Comparison State	In-Person
8/10/2006	Personal Interview	Sue Bowler	Administrator for Families and Children, Rhode Island Department of Children, Youth and Families	Beth Caldwell	Comparison State	In-Person

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## Appendix D

### Arizona Vision and Family Involvement Framework

(<http://www.azdhs.gov/bhs/jk.htm>, August 7, 2006)

The “**Arizona Vision**,” for children is built on twelve principles to which ADHS and AHCCCS are both obligated and committed. The Arizona Vision states:

In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults.

Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child’s family’s cultural heritage.

1. **Collaboration with the child and family:** Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. **Functional outcomes:** Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child’s condition and minimizes safety risks.
3. **Collaboration with others:** When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child’s team includes the child and parents and any foster parents, any individual important in the child’s life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child’s teacher, the child’s Child Protective Service and/or Division of Developmental Disabilities case worker, and the child’s probation officer. The team (a) develops a common assessment of the child’s and family’s strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan and (d) makes adjustments in the plan if it is not succeeding.
4. **Accessible services:** Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

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5. **Best practices:** Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based “best practice.” Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member’s lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.
  6. **Most appropriate setting:** Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child’s needs. When provided in a residential setting, the setting is the most integrated and most home- like setting that is appropriate to the child’s needs
  7. **Timeliness:** Children identified as needing behavioral health services are assessed and served promptly.
  8. **Services tailored to the child and family:** The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
  9. **Stability:** Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children’s lives, including transitions to new schools and new placements, and transitions to adult services.
  10. **Respect for the child and family’s unique cultural heritage:** Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

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11. **Independence:** Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self- management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.
  12. **Connection to natural supports:** The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

## Arizona's Family Involvement Framework

Endorsed by Arizona's Children's Executive Committee  
February 2004

### Definition:

Family involvement is a parent/professional partnership. This partnership begins with the child and his or her family, respects their preferences, interests, needs, culture, language and belief systems, provides opportunities and mechanisms for families to identify their roles within the structure of the system of care and reflects the family's voice.

### Defined by Action:

Agencies that have the full spectrum of family involvement . . .

- Provide value driven training by families to administrative, management and front line staff that emphasizes, re-iterates and illustrates the requirement for and value of family involvement – respect and partnering with families.
- Provide on-going training to staff that defines, demonstrates and reinforces the necessity for family voice and choice in service provision.
- Provide formal orientation, training and encouragement for families to become involved in the system of care. Opportunities for family involvement are developed and participation is solicited, input is valued and supported.
- Receive feedback related to the effectiveness and efficiency of the system of care and actively recruit family input in plans for correction, revision and change.
- Provide for family member membership and full participation on policy-making bodies and system development workgroups
- Provide opportunities for 1:1 family support, family mentoring and networking.
- Demonstrate sensitivity to the trust issues that may develop between family members, employed family support personnel and the agencies.

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- Provide orientation to families about how the system works and how to make it work for their children. Sharing available information and partnering with the families is a part of how the agency operates. With information, families can be prepared to participate as equal partners in the treatment team and process.
  - Demonstrate respect for the family's opinion regarding treatment decisions and progress evaluation through mutual exchange of information and ideas.
  - Promote and facilitate family involvement and coordination with other agencies the youth may be involved with. Utilize joint meetings and consistent case plans.
  - Demonstrate a culture of respect that permeates the agency – families need to be respected and listened to, their input valued and considered in the treatment planning for the child.
  - Assess and consider the family's readiness for involvement, their ability to assume tasks on behalf of their child, and / or the system.
  - Include families in all trainings – even those that are specifically for clinicians -- to assist with promoting the culture of family involvement. ■

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## Appendix E:

### **New York State Office of Mental Health Desired Outcomes for Children's Residential Programs 2004/2005**

It is the intent of the New York State Office of Mental Health to ensure that all children's residential programs truly provide safe, therapeutic, short-term and effective living and treatment environments for the children and families they serve, as evidenced by meeting with success across a number of outcome areas, including.

#### **Child and Family outcomes:**

- expanded array of child and family skills learned;
- increased awareness of and belief in own strengths;
- improved, earlier and sustained connections to community resources (especially those correlated to meeting with success in family, educational, social and community domains);
- earlier and sustained successful reunifications in the community;
- increased child and family satisfaction with services;

#### **Agency staff outcomes:**

- improved focus on child strengths and skill building;
- increased focus on collaboration with and respect for families;
- increased attention to addressing the individual clinical needs of each child, including comprehensive focus on trauma issues (e.g., loss, abuse);
- improved focus on addressing the individual learning, developmental and emotional needs of each child (e.g., learning styles, sensory issues);
- increased staff skills in using collaborative, problem solving and respectful child interactions, as opposed to control, power-focused interactions;
- improved team work (e.g., family, child, staff, community members) and staff skills in treatment planning and delivery, especially related to all members of the team working towards and putting primary attention on the same goals for each child (e.g., working with family and system of care to ensure successful transition to the community);
- evidence of leadership staff sustained commitment to achievement of all outcomes;

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## Agency outcomes:

- Specific attention, which is evident in all program components, to the goal of treatment being individually defined for each child at admission (thus removing all evidence of the residential program being viewed as a long term treatment solution).
- improved and more coordinated administrative, training, supervision and evaluation systems;
- improved systems for ensuring that clinical and learning needs are addressed individually, comprehensively, flexibly and with state-of-the-art interventions;
- significantly improved focus of all aspects of program delivery on the needs of the child and family related to successfully living in the community (including developed relationships and evidence of regular interface with SPOA, schools, and entire system of care);
- increased use of program systems that focus on problem solving, collaboration and respect, as opposed to controlling and punitive systems (i.e., point based motivation systems that result in frequent loss of privileges);
- reduced length of stay;
- reduced use of restraint, seclusion and physical holds; and
- reduced number of untoward incidents. ■



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# Appendix F

## Resources for More Information

- Friedman, R. (1999). *A conceptual framework for developing and implementing effective policy in children's mental health*. Tampa, Florida: University of South Florida, The Louis de la Parte Florida Mental Health Institute. [www.fmhi.usf.edu/cfs](http://www.fmhi.usf.edu/cfs)
- McCarthy, J., Meyers, J., & Jackson, V. (2000). *The adoption and safe families act: Exploring the opportunity for collaboration between child mental health and child welfare service systems*. Washington, D.C.: National Technical Assistance Center for Children's Mental Health. [gucdc.georgetown.edu](http://gucdc.georgetown.edu)
- Stark, D. (1999). *Collaboration basics: A companion guide — strategies from six communities engaged in collaborative efforts among families, child welfare and children's mental health*. Washington, D.C.: National Technical Assistance Center for Children's Mental Health. [gucdc.georgetown.edu](http://gucdc.georgetown.edu)
- Stroul, B., and Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances*. Washington, D.C.: National Technical Assistance Center for Children's Mental Health. [gucdc.georgetown.edu](http://gucdc.georgetown.edu)
- Weber, M. and Yelton, S. (1996). *The role of the child welfare system in systems of care*. In B.A. Stroul (Ed). *Children's Mental Health: Creating Systems of Care in a Changing Society* (pp.215–234). Baltimore, MD: Paul H. Brookes Publishing Co., Inc. ■

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## Appendix G

### Sources and Methodology for Analysis of New Jersey Utilization and Expenditures

Table G1. Sources of New Jersey Data		
Data Source	Original Study	Update
Medicaid claims and eligibility files sorted by county of residence and service type	PRO Data from 1998	Summary of claims for Medicaid eligible children for Medicaid services produced by New Jersey's Medicaid agency for 2004 and 2005
DYFS	Residential Placements and Expenditures from FY 2000 by county of residence	2004 and 2005 DYFS contributions for claims processed through the consolidated Medicaid billing system
DMHS Net Expenditures	FY 1999 USTF Data	2004 and 2005 DCBHS contributions for claims went through the consolidated Medicaid billing system
Psychiatric Community Residence Costs	Allocated to county(s) served based upon percent of SED children in the program's service area	2004 and 2005 Medicaid and non-Medicaid residential service expenditures paid through the consolidated Medicaid billing system
Ambulatory service costs	Allocated according to distribution of all other expenditures (DYFS, Medicaid, and DMHS psych comm residences)	2004 and 2005 Medicaid and non-Medicaid outpatient and community expenditures paid through the consolidated Medicaid billing system.

<b>Table G2</b> <b>New Jersey Compared to Other Entities Characteristics of Medicaid Data</b>				
<b>State or County</b>	<b>Year</b>	<b>Unduplicated or average?</b>	<b>Oldest age in range</b>	<b>Includes Schip Y/N?</b>
NJ Medicaid + MH	2005	Unduplicated	20	Plan A
NJ Medicaid + MH	2004	Unduplicated	20	Plan A
SE PA Counties	2005	Unduplicated	17 (20 – Phil.)	N
Maryland	FY2005	Unduplicated	17	N
Massachusetts Total	FY05	Average members	20	Y
MNSP SMSA Medicaid only	2004	N/A	17	Y
Arizona	June 2005	Average	Unknown	Y
Maricopa County	July-Dec. 2002	Average members		

<b>Table G3</b> <b>Comparison of New Jersey to Other Entities Data Specifications and Limitations</b>	
<b>State/Measure</b>	<b>Specification or Limitation</b>
<b>New Jersey</b>	
Consolidated children served	Duplicated total of inpatient residential and outpatient. Excludes non-Medicaid children served outside of the consolidated system.
SE PA Counties	Sum of children served and expenditures for Bucks, Delaware, and Montgomery county 2005 expenditures and Philadelphia county FY05 data.
Medicaid and MHA Children Served	Excludes Delaware County non-Medicaid children served
Medicaid and MHA Expenditures	Excludes Delaware and Philadelphia County non-Medicaid expenditures
Average Cost Per Child Served	Excludes Delaware and Philadelphia County non-Medicaid children served and expenditures
<b>Maryland</b>	
Medicaid and MHA Children Served	
Medicaid	Excludes state funded services named 'State Medicaid'. Total federal Medicaid expenditures exceeds sum of service totals due to adjustments equal to about 3% of total.
Mental Health Authority	Includes state funded 'State Medicaid' services provided to Medicaid eligibles.
Combined Inpatient	May double count 22 Med eligibles getting non-Med inpatient if they also get Medicaid paid inpatient.
Combined Residential	May double count 173 Med residential users of non-Med services if they also receive Med residential services.
Combined Community	Assumes that State Medicaid users of non-Medicaid services also counted as users of Medicaid community services.

Table G3		Continued
Comparison of New Jersey to Other Entities Data Specifications and Limitations		
State/Measure	Specification or Limitation	
Maryland (Continued)		
Community Outpatient Users	Users of non-CMHC outpatient services were assumed to also be using and therefore counted in CMHC user figures. This would undercount any users for whom this assumption is not true.	
Combined children served	Excludes 800 Medicaid recipients getting non-Medicaid services, assume that they probably also are counted among those receiving Medicaid services	
Massachusetts		
Medicaid	Includes substance abuse services and mental health services in its counts.	
Medicaid Children Served	Fee for Service Unduplicated total computed as duplicated total of children receiving inpatient plus those receiving community/outpatient/diversionary/ residential	
Combined Residential/Community	Residential services included in community/ outpatient category.	
Medicaid Expenditures	Total includes small amounts of 'other mental health services' not assigned to a category	
MHA Expenditures and Children Served	Determining children served and expenditures required multiple estimates due to contracts and reporting data falling across service level boundaries and methods of payment that don't require unit based reporting	
MHA Expenditures	Excludes up to \$25 million in services provided by state personnel, including case management and state hospital care	
Medicaid and MHA Children Served	Totals exclude estimated 45% of MHA service recipients who are also on Medicaid and are presumed to receive Medicaid services	

<div> <div>Table G3</div> <div>Continued</div> </div>	
Comparison of New Jersey to Other Entities Data Specifications and Limitations	
State/Measure	Specification or Limitation
<b>Minnesota St. Paul Statistical Area Counties</b>	Includes children served by Medicaid, state health plans, and in county mental health system.
Children Served in Inpatient	Duplicated total of children served in Children's Regional Treatment Center Inpatient Treatment and Community Children's Psychiatric Inpatient under fee for service and managed care.
Children service in Residential	Children's Residential Treatment, Rule 5
Milwaukee County – children served	Unduplicated total of children served in Medicaid, SCHIP, County mental health services, Wraparound Milwaukee, and state programs offering coverage similar to Medicaid
<b>WrapAround Milwaukee</b>	
Total Expenditures	Estimate: excludes fee for service billing for crisis intervention serving all Milwaukee youth
Residential Expenditures	Estimate: a duplicated total of residential treatment, plus 5/8 of kids in foster care who are likely to be in treatment foster care
<b>Maricopa County</b>	6 month period for data collection. 6 month penetration rates are lower than 12 month rates.

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## Description of Comparison Entities

### South Eastern Pennsylvania Counties

**Health Choices** is Pennsylvania's Medicaid program. It serves children (and adults) eligible for Temporary Assistance to Needy Families (TANF), Healthy Beginnings (pregnant women and/or low income children), Healthy Horizons (low income Medicare consumers), Supplemental Security Income (SSI), General Assistance-State Only, and federally assisted General Assistance.... Pennsylvania has a long history of efforts to develop local systems of care for children with or at risk for serious disorders, following the principles and values of the federal Child and Adolescent Service System Program (CASSP).<sup>11</sup> For many years, Pennsylvania has worked to institutionalize in every county a CASSP infrastructure to serve children with or at risk for serious disorders, including a CASSP Coordinator, a range of services, and interagency collaboration at the service and system levels. (Pires, S. A., 2002).

SE Pennsylvania Counties serve as mental health authorities. As such, they administer state and county funds for children's mental health as well as purchase and oversee or (in the case of Philadelphia) actively provide managed care of Medicaid behavioral health services for children. Our data include the counties of Delaware, Montgomery, Bucks, and Philadelphia. To get a total for each county, we added their data together, assuming that there would be little overlap of children moving from one county to another. Notably, we are missing data on non-Medicaid services from Delaware County, which was unable to provide them. In the remaining counties, Non-Medicaid children constituted 6% to 16% of all children served, suggesting the magnitude of the children we missed. In addition, Philadelphia County's non-Medicaid expenditures were not provided, and they are therefore not included in expenditure totals, and non-Medicaid children served were not included in average costs per service user. This will clearly tend to undercount PA children and expenditures.

It is important to note that Pennsylvania has very expansive eligibility criteria for disabled children to qualify for Medicaid. Disabled children at virtually all income levels can qualify. This likely means that Pennsylvania's Medicaid caseload includes a higher percentage of high cost children than other states.

### Maryland

The state of Maryland has a behavioral health carve out managed by its counties and a statewide Administrative Services Organization (ASO), which also is a conduit for certain non-Medicaid services. Maryland provided data on three types of services: Medicaid services provided to Medicaid eligible children, Non-Medicaid services provided to children not eligible for Medicaid, and Non-Medicaid services provided to Medicaid eligible children. Our figures combine all Non-Medicaid services, including those received by Medicaid eligible individuals. We have assumed that all Medicaid children receiving Non-Medicaid services are also receiving Medicaid services. For this reason, the counts of these children are not included when we combined non-Medicaid with Medicaid in our totals, though the costs of their



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services are included. This means that the estimates of total children served may be slightly undercounted. The Maryland data on service categories was drawn from data developed at different times than that for the totals. We found discrepancies of approximately 4% in costs, which we judged were not material to our analysis.

## **Massachusetts**

Massachusetts provides a comprehensive Medicaid behavioral health benefit through HMOs, a behavioral health carve out partnered with its Primary Care Physician Plan (PCCP) plan, and some fee for service. Its Mental Health Authority also provided data, but due to contracts and payment rates that cover more than one type of service, we were unable to assign all of its service related costs to a level of care. Therefore its expenditures and children served by the MHA are somewhat understated. The MHA knows that approximately 45% of the children it serves get Medicaid services as well, so we reduced the MHA count by that amount when calculating total children served. Massachusetts Medicaid agency provided comprehensive data on both mental health and substance abuse services for children. This overstates both children served and expenditures when compared to the rest of our mental health only data.

## **Minneapolis/St. Paul/Bloomington Metropolitan Statistical Area**

We selected those Minnesota counties deemed by the Census Bureau to be significantly linked with the core communities of Minneapolis and St. Paul to create a more urbanized region of the state that would provide a more useful comparison to New Jersey. Our set of counties excludes a few Wisconsin counties included in the Census defined area. Minnesota has state oversight of a county administered system. They produce annual utilization reports that integrate data from their reporting system to the state MHA and the Medicaid system, which also includes some state funded coverage similar to Medicaid. Any tribal services are excluded.

## **Milwaukee County, Wisconsin**

The state of Wisconsin recently did a study of the provision of public mental health services for children in Milwaukee County. These figures included Medicaid, SCHIP, County mental health services, Wraparound Milwaukee, and state programs offering coverage similar to Medicaid. They unduplicated these figures to come up with their number of children served. No associated expenditure or service utilization data was available.

## **WrapAround Milwaukee**

This pioneering system of care program accepts only children determined to be at risk of residential or correctional placement. It receives capitation payments from a combination of Medicaid, the child welfare agency and the courts. A high proportion of children served are court involved. The inclusion of this group and their associated mental health funds makes WrapAround Milwaukee different from New Jersey and some of the other states and counties.

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Wraparound Milwaukee is housed within the Milwaukee County Mental Health Division, Child and Adolescent Services Branch, which acts as a public care management entity. Wraparound Milwaukee organizes an extensive provider network and employs, directly or by contract, care coordinators, who work within a wraparound, strengths-based approach. (Pires, S. A., 2002).

In calculating children served in residential, we added those served in Residential Treatment Centers to an estimate of the children served in Therapeutic Foster Care. To get this estimate, we multiplied total children served in Foster Care times 5/8, the average balance between therapeutic and regular foster care in the system, according to its director. However, by totaling therapeutic foster care and residential care, it is likely that we are double counting some children receiving services in both settings during the year. This therefore overstates our residential utilization figures to some degree.

## **Maricopa County, Arizona**

Maricopa County is the largest region of a statewide managed care behavioral health carve out. ValueOptions is the managed care company that administers both Medicaid and some state services. This system has been faced with two major law suits, one affecting children. A statewide settlement agreement focused on the children's behavioral health system. The JK Settlement Agreement has required the development of comprehensive children's system transformation requiring provider agencies to implement child and family teams to plan services for their children, and to create comprehensive networks of services and supports needed to carry out the plans. ■







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