

---

# State and Local Descriptions (continued)

## II. Sample Sites Using Existing Standardized Protocols (Including Proprietary and Open Domain)

---

### Hawaii (Group Two: Existing Standardized Protocols)

- Child and Adolescent Functional Assessment Scale (CAFAS)
- Child and Adolescent Service Intensity Instrument (CASII)
- Child Behavior Checklist (CBCL)
- Youth Self Report (YSR)



---

### Overview

Hawaii provides an extensive and well-documented example of statewide reform in the delivery of children’s public mental health services. The health system infrastructure for Hawaii includes the State Department of Health (DOH), which oversees three separate administrations: Behavioral Health Services, Health Resources, and Environmental Health. The Behavioral Health Services Administration holds the statutory responsibility to provide “preventive, diagnostic, treatment and rehabilitative services for emotionally disturbed and mentally ill children and youth,”<sup>41</sup> which it dispenses via its Child and Adolescent Mental Health Division (CAMHD). The Behavioral Health Services Administration also includes the Adult Mental Health Division and the Alcohol and Drug Abuse Division, while the Developmental Disabilities Division resides separately within the Health Resources Administration. The Child and Adolescent Mental Health Division is well acquainted with the CASSP<sup>42</sup> principles, having been the recipient of multi-year, federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding. In redesigning the behavioral health care delivery system for children and youth in Hawaii, policy makers integrated the concepts underlying CASSP into their official philosophy. The impetus to redesign the delivery system was generated by several factors, which created a force for change, including: increased population, demographic shifts, and a consent decree related to the Individuals with Disabilities Education Act (IDEA), relating specifically to behavioral health services for children in special education.

Hawaii’s child and adolescent mental health system has grown in capacity in the last ten years so that it now serves over one thousand children and youth with emotional and behavioral challenges. Accommodation to this need for service system growth has been greatly facilitated by collaboration between the Child and Adolescent Mental Health Division and the Department of Education, including statewide implementation of School-Based Behavioral Health (SBBH) programs, and partnership with the statewide family organization, Hawaii Families As Allies.

---

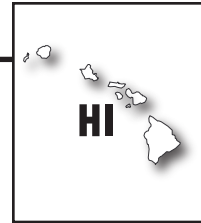
41 Hawaii Revised Statutes, §321-171

42 Stroul, B. A. & Friedman, R. M. (1994, rev. ed.). A system of care for children and youth with severe emotional disturbances. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

---

## Hawaii (Group Two: Existing Standardized Protocols)

- Child and Adolescent Functional Assessment Scale (CAFAS)
- Child and Adolescent Service Intensity Instrument (CASII)
- Child Behavior Checklist (CBCL)
- Youth Self Report (YSR)



---

## Goals

The CAMHD and its provider agencies, including satellite clinics, have identified five distinct goals regarding Hawaii's children and youth and their families:

- (1) CAMHD will facilitate and support the shared ownership of the CAMHD vision, mission, initiatives and achieved outcomes.
- (2) CAMHD and its providers will consistently adhere to the Hawaii Child and Adolescent Service System Program Principles<sup>43</sup>
- (3) CAMHD and its service providers will consistently apply the current knowledge of evidence based services (EBS) in the development of individualized plans. The design of the mental health system will facilitate the application of these services.
- (4) CAMHD and its provider agencies will routinely evaluate performance data and apply the findings to guide management decisions and practice development.
- (5) The business principles implemented throughout CAMHD and its provider agencies will insure high quality and accountable operations.<sup>44</sup>

An evidence-based task force was convened in 1999 and “practice guidelines” were issued with quarterly updates and a biennial comprehensive review. Gradually, these guidelines have begun to shape practice within the CAMHD network of providers; one of the evidence-based practices, Multi-Systemic Therapy (MST), is now a major initiative with manualized training provided to several contracted providers. Intensive case management or “mental health care coordination,” which has been found effective in assuring the provision of needed mental health services, is available to families within the family guidance centers.

The current initiative by CAMHD uses formal instruments and clinical guidelines to ensure that every child who meets criteria for more intensive services is fully assessed and appropriate treatment selected<sup>45</sup>. Youth with intensive services needs also continue to be identified in public schools under the Individuals with Disabilities in Education Act (IDEA)<sup>46</sup> and the juvenile courts. Hawaii utilizes the Child and Adolescent Functional Assessment Scale (CAFAS) to determine eligibility for intensive services provided by CAMHD and its satellite clinics. The threshold for

---

43 Hawaii Task Force (1993). State of Hawaii Child and Adolescent Service System Program (CASSP) Principles. Available <http://www.hawaii.gov/health/mental-health/camhd/library/pdf/cassp.pdf>.

44 State of Hawaii State Department of Health [Website]. <http://www.hawaii.gov/health/mental-health/camhd/>

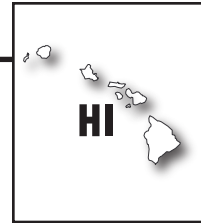
45 Daleiden, E. L. (2003). Child Status Measurement: Operating Characteristics of the CALOCUS and CAFAS for the Period of July 1, 2000 to June 30, 2003; Version 2-24-04. Hawaii: Department of Health, Child and Adolescent Mental Health Division. Available <http://www.hawaii.gov/health/mental-health/camhd/library/pdf/rptheval/mr/mr001.pdf> <<http://www.hawaii.gov/health/mental-health/camhd/library/pdf/rptheval/mr/mr001.pdf>>

46 The Individuals with Disabilities Education Act (IDEA), Public Law 94-142 (formerly Education of All Handicapped Children Act). For an overview of the Act, see Apling, R. & Jones, N. L. The Individuals with Disabilities Education Act (IDEA): Overview of major provisions (CRS Report for Congress, RS20366). Washington, DC: Congressional Research Service. Available <http://usinfo.state.gov/usa/infousa/educ/files/ideaover.pdf> <<http://usinfo.state.gov/usa/infousa/educ/files/ideaover.pdf>>.

---

## Hawaii (Group Two: Existing Standardized Protocols)

- Child and Adolescent Functional Assessment Scale (CAFAS)
- Child and Adolescent Service Intensity Instrument (CASII)
- Child Behavior Checklist (CBCL)
- Youth Self Report (YSR)



---

intensive services for youth under Hawaii's managed Medicaid program is a score of > 80 on the CAFAS<sup>47</sup> and a DSM-IV qualifying diagnosis. Such youth become eligible for intensive services, called the Support for Emotional and Behavioral Development program (SEBD)<sup>48</sup> and are served as part of CAMHD's behavioral health plan under Medicaid. The clinical instruments used in the Hawaii system—CAFAS, CALOCUS (now CASII),<sup>49</sup> and Achenbach<sup>50</sup> profiles—are used concurrently both for evaluation purposes and to support appropriate decision making, but they are not used in isolation. All scores are combined with clinical judgment by the array of trained staff at the family guidance centers so that levels of care are reviewed in an individual context.

## Background

Hawaii's children and families benefited significantly from a federal Reduction of Seclusion and Restraint grant, which provided resources for supporting delivery system change. Formal functional measures, such as the CAFAS and the Achenbach System of Evidence-Based Assessment (ASEBA), including the parent and school CBCL reports and the YSR, had been used for several years within CAMHD. In 2000, the CALOCUS (now known as the CASII) was also added. These three main instruments are tracked and reported quarterly, then summarized annually in the CAMHD Annual Report. Standardized use of the measures is a major component of the accountability systems of CAMHD. The effectiveness of schools and Family Guidance Centers is also monitored by a sampling of intensive case reviews annually (formerly referred to as "service testing"), looking for qualitative information to add to the quantitative data generated by use of the clinical instruments. Additional measures are used with some of the subgroups within the child and adolescent population, such as juvenile sex offenders. As the result of the judicial consent decree, CAMHD was able to combine efforts with the Hawaii educational authority to respond to the emotional and mental health needs aspects of the requirements of the IDEA. This double authority created a new environment within which significant changes could be made in the overall way that agencies related to each other and the process of clinical decision making. The state of Hawaii has mandated a goal for all child treatment to be related to the use of the selected clinical guidelines, recognizing that this is difficult to enforce. These guidelines and standards are known as the Interagency Performance Standards and Practices Guidelines (IPSPG); components are updated regularly and a major revision occurs when new contracts are issued. Staff members from the Department of Health

---

47 Hodges, K. (1998) Child and Adolescent Functional Assessment Scale (CAFAS). Ann Arbor, MI: Functional Assessment Systems

48 Readers are encouraged...criteria. See State of Hawaii, Child and Adolescent Mental Health Division (6 July 2005). Support for emotional and behavioral development (SEBD) referral process. Available <http://www.hawaii.gov/health/mental-health/camhd/library/pdf/sebd/a7393.pdf> <<http://www.hawaii.gov/health/mental-health/camhd/library/pdf/sebd/a7393.pdf>> .

49 American Academy of Child & Adolescent Psychiatry (s.d.). CASII: Child and Adolescent Service Intensity Instrument. Available <http://www.aacap.org/clinical/CASII/index.htm> <<http://www.aacap.org/clinical/CASII/index.htm>>

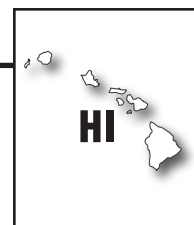
50 Achenbach, T.M. (1991). Integrative Guide for the 1991 CBCL/4-18, YSR, and TRF profiles. Burlington, VT: University of Vermont, Department of Psychiatry.

---

---

## **Hawaii** (Group Two: Existing Standardized Protocols)

- Child and Adolescent Functional Assessment Scale (CAFAS)
  - Child and Adolescent Service Intensity Instrument (CASII)
  - Child Behavior Checklist (CBCL)
  - Youth Self Report (YSR)
- 



collaborate with Department of Education staff to update the performance standards, along with family organizations, providers, university faculty, and state policy makers. All clinical staff in delivery sites have been trained in administration of the CAFAS, the CALOCUS (CASII) and the CBCL and YSR. Some of the data elements may be collected by phone interview. The scores for each child are put together with clinical information to create a mental health treatment plan and a coordinated service plan.

### **Description**

Selection of which instruments to use was initially based on expert technical assistance from SAMHSA, the federal court monitor, and the University of South Florida Research and Training Center for Children’s Mental Health. Leadership by the state child mental health director and the medical director within CAMHD helped move the assessment model adoption process. In trying to “help the most people” within the overall population, the state’s systematic plan involving functional measures at six month intervals and clinical guidelines to identify and treat high-need youth has two purposes: (1) to track individual clinical status and contribute to level of care determinations, (2) to monitor overall system performance. There are three ways to be identified as high-risk and enter the system; one is via the school, with mental health services that are mandated by the child’s 504 plan or IDEA plan. Another way is to have treatment mandated by the judge in juvenile court, and the third is via mental health SEBD eligibility, based on a CAFAS score of > 80. A child with a CAFAS score of 60 or above can be considered “provisionally qualified” for SEBD and be eligible for services but must be reviewed at six month intervals rather than annually.

### **Individualized, Culturally Competent Family Focus**

Hawaii, which has an “amalgam” culture of diverse heritages, has been committed to implementing the assessment model with maximum congruence to the CASSP principles. As a result, a range of interpreters and multi-cultural, multi-lingual staff have been involved in the process. Family members have participated in local committees and management teams, as well as in planning, policy-making and performance measurement activities. Families and other stakeholders (schools, child welfare,, mental health, developmental disabilities, juvenile justice) share decision-making at the level of the individual child. The CAMHD attempts to maintain fidelity to family-focused care. Once a child is determined to be eligible for services, assessment tools are used only to inform clinical judgment, and final care delivery decisions are made in the treatment team, on which families and youth are key members.

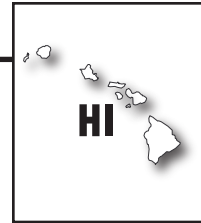
### **Impact of Service Availability**

Use of the guidelines themselves is not seen as impacting access, but the new assessment model is co-managed and, therefore, hospital and clinic staff, i.e., mental health care coordinators collaborating with intensive case managers, are required to be responsive to each other and do whatever is necessary to move the child to the appropriate level-of-care in a timely

---

## **Hawaii** (Group Two: Existing Standardized Protocols)

- Child and Adolescent Functional Assessment Scale (CAFAS)
- Child and Adolescent Service Intensity Instrument (CASII)
- Child Behavior Checklist (CBCL)
- Youth Self Report (YSR)



fashion. If services are not available, the care coordinator can go outside the network (through the use of flexible funds), or a child can remain where he/she is, with bridge/supplemental services added to bring the level-of-care as close as possible to the one for which they are waiting. The active partnership of school personnel in the shared goal of keeping children in the community has aided the ability of the system to individualize services.

## **Training, Fidelity and Oversight**

Interagency Performance Standards and Practice Guidelines (IPSPG) were created by the Department of Education and the Department of Mental Health together, and the state is bound to uphold these standards, which are posted publicly on their website. Guidelines are updated, based on a best-practice system in place, which reviews current research and reports changes. Training takes place in three ways:

- Face-to-face, practice development meetings with “stand-up” trainings
- “Mentoring” of selected agencies as needed (“focused consultation/training”) on request
- CME credit and/or supervision credits for the individual who completes training

Practitioners, mostly located within satellite public clinics, are re-qualified annually based on refresher courses in measurement tool administration. External contracts with provider agencies also require use of the measures, which is outlined in the IPSPG manual or “green book.”

The CAMHD Central Office monitors compliance with guideline adherence, and each clinic has a quality assurance specialist and a fiscal specialist who report relevant data to track clinic participation in the process. Care Coordinators report to supervisors who oversee timeliness of completion of necessary measures at required intervals. Achenbach measures (CBCL, YSR and TRF) are most challenging to gather due to responsibility lying outside of CAMHD administration. The CBCL is to be done by parents, YSR is completed by the youth, and the TRF is designed for teachers. The CAFAS and CALOCUS (CASII) can be completed by the “active clinician” for each case and do not require added face-to-face contact with the family or child.

## **Experience to Date**

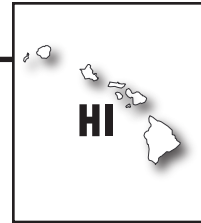
Because Hawaii is a small state, it has been able to access key players relatively easily. This has also meant that working relationships have been created among top and mid-level managers. CAMHD leaders stress that it is necessary to have substantial public, professional (across all mental health disciplines) and consumer buy-in in order to implement major changes such as these in a state system. Hawaii found it helpful to gather interest groups and diverse stakeholders at the beginning in order to devise a collaborative strategic design. The parent organization, “Families as Allies,” helped at every level of planning and implementation. Unlike many systems of care settings, Hawaii reports that of all the professional interfaces, collaboration with schools has run the most smoothly. They credit the now ten-year relationship of shared

---

---

## **Hawaii** (Group Two: Existing Standardized Protocols)

- Child and Adolescent Functional Assessment Scale (CAFAS)
- Child and Adolescent Service Intensity Instrument (CASII)
- Child Behavior Checklist (CBCL)
- Youth Self Report (YSR)



---

ownership at the service level for facilitating the level of school participation and support. Individual school personnel seeking to have children placed out of the community have learned that collaboration with mental health staff can work well to maintain challenged students in their local schools.

As early results are being analyzed, it appears that better outcomes are being reported, with increased rates of high-school graduation and decreased juvenile justice involvement compared to 1999, as well as decreased consumer complaints. Mental health costs, while not the primary focus, have also decreased since the introduction of system guidelines for service selection, although community-based vendors have begun to ask for increased rates to handle their new, more complex caseloads. With the SEBD population included in the CAMHD system of care, the federal match contribution through various programs of state Medicaid has increased significantly.

Collaboration with the University of Hawaii medical school has led to resident rotations in the family clinics. The residents gain experience in administration and see the value of evaluation instruments and guidelines for level of care, which has helped disseminate the goals and the skills necessary for integration of these concepts into future practice. The eight child psychiatrists employed by CAMHD are all clinical faculty of the medical school Department of Psychiatry; most supervise residents, some conduct seminars and lectures in specialized community psychiatry topics, and others conduct research with resident involvement. Social Work and Psychology trainees from the University of Hawaii also benefit from opportunities for internships and practicum experiences as well as the chance to participate in clinical research. CAMHD participation in the provision of graduate mental health training supports the development and sustainability of a mental health workforce trained in the CASSP principles.

## **Major Benefits, Concerns and Lessons Learned**

Challenges related to implementation of statewide clinical guidelines include financial and personnel investment for initial training and ongoing education and the need for increased written production by staff, as documentation is required to support reliable use. Notable strengths of the instruments selected are: CAFAS and Achenbach tools support assessment and long-term planning, with trends observed over time. CALOCUS (or CASII) provides minute to minute acuity monitoring and also takes clinicians out of the conventional “step-wise” movement in level of care selection, instead using intensity of need to guide treatment decisions. Major benefits are the improved quality of mental health services to the state’s children and families, as well as an increased evidence-base that is now contributing to clinical treatment decisions.

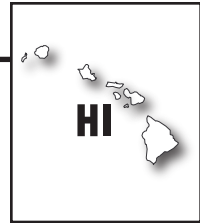
The greater evidence base underlying decision-making has been supported by the highly structured accountability throughout the system. This comprehensive accountability has led to a resulting increase in available data for analysis. The Child and Adolescent Mental Health Division reports that the average entry level CAFAS score is 120, with the average exit score

---

---

**Hawaii** (Group Two: Existing Standardized Protocols)

- Child and Adolescent Functional Assessment Scale (CAFAS)
- Child and Adolescent Service Intensity Instrument (CASII)
- Child Behavior Checklist (CBCL)
- Youth Self Report (YSR)



---

around 70. Utilization of out-of-state placements has dropped significantly from 80 youth to less than 10. Similar decreases are noted in residential hospitalization rates and length of treatment in community residential programs. Despite these gains, the CAMHD 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.