APPENDIX C: POWERPOINT PRESENTATIONS BY PANELISTS

GERALDINE TONICH
Parent Representative
Family Resource Specialist
Family Ties
Westchester County, NY

GERALDINE TONICH

A Parent's Story

Matthew, Age 9

- **Early Years**
  - Birth to Age 3 Opportunities — Missed
  - 3 Years to 5 Years Pre-Ed. — Committee on School Special
  - Age 5 — Diagnosis of Autism

Family Support Advocacy

Introduction to Family Support (Family Ties) through a Community Based System of Care.

1. Advocacy
2. Peer Support
3. Sibling Group

GERALDINE TONICH

Systemic Issues

- Role of Pediatrician
- School Response
- Autism "Catch 22":
  Autism diagnosis may prevent a child from receiving mental health treatment services

On-Going Challenges

- Effect on other children in the family
- Families Need In-Home Help
- Difficulty in finding a child psychiatrist for a younger child

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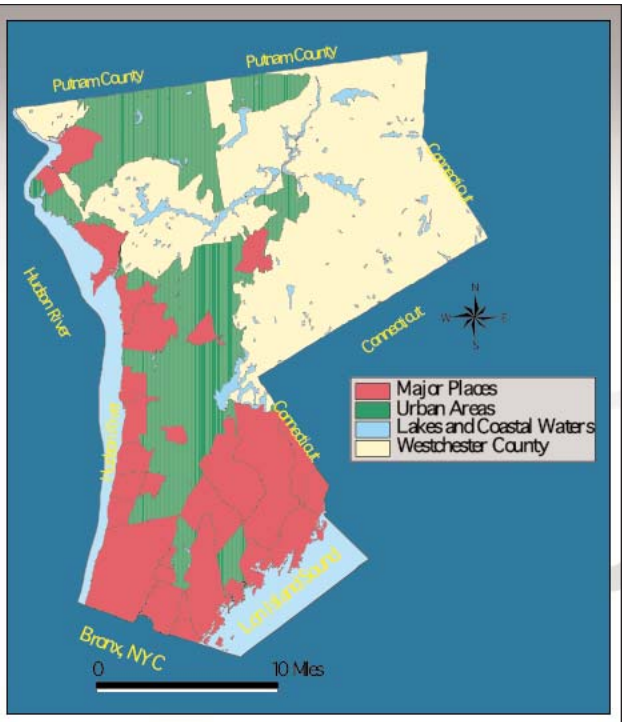
Director, Children's Mental Health
Westchester County Department of Community Mental Health

MYRA ALFREDS, C.S.W.

Westchester County, NY

Urban Areas and Major Places



Challenges & Differences

MR/DD

- State Driven
- Higher Ratio Service Coordination
- Programmatic Family Support
- Dispute Resolution
- Adult Driven
- Life long

Mental Health

- County Driven
- Lower Ratio Intensive Case Management
- Community-Based Family Support
- Collaborative Model
- Child/Adult
- Time Limited

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Cross System Issues

- Pediatricians do not routinely screen for Mental Health & Developmental Disabilities.
- Parents must often choose one system or the other.

Definition of a System of Care

A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.

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System of Care Principles & Values

- Community-Based
- Family Driven
- Culturally Competent
- Team Developed & Supported
- Never Give Up
- Individualized
- Strength Based
- Flexibly Funded
- Supports & Services that Every Child Needs

Community Network for Children & Families

10 Community-Based Networks
2 Early Childhood Networks
1 Transitional/Aging-Out Network
(County-Wide)

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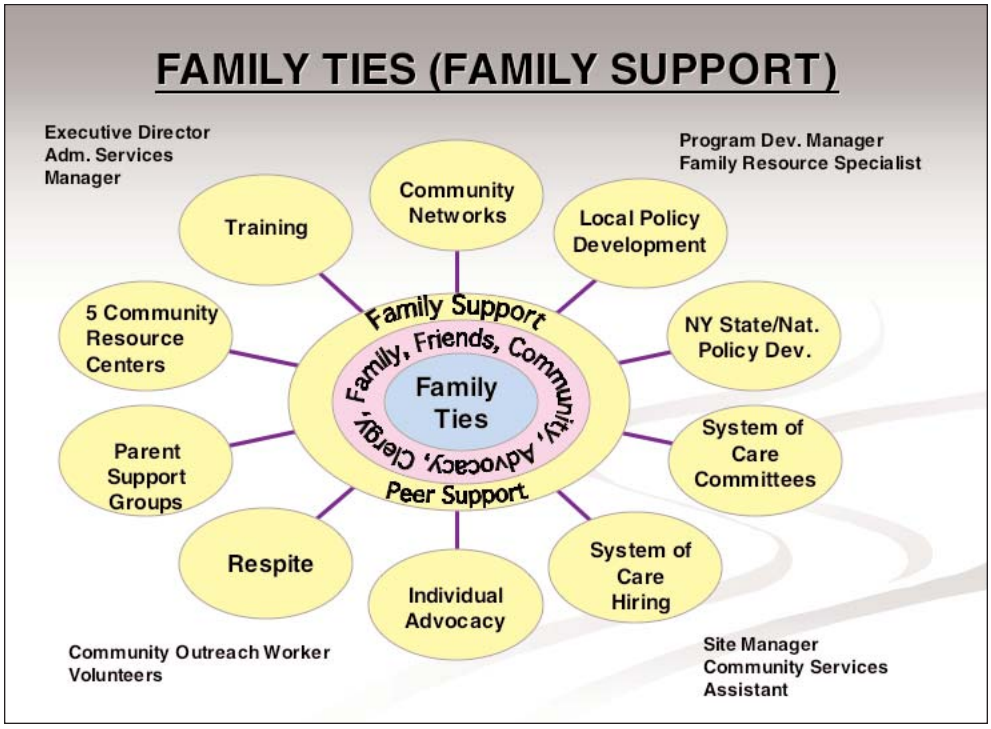

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FEDERAL RECOMMENDATIONS

- Put the Needs of Children with Co-Occurring Disorders Front & Center in the Federal Agenda. Utilize the New Freedom Commission Report as a Social Marketing tool and foster Policy Development, Planning, & Partnerships with Parents & Professionals across all Federal Agencies;
- Use the System of Care Approach as a Best Practice Model. Include all children who could benefit from help from more than one system, not only those who meet strict eligibility criteria. Support the establishment of independent *Wraparound Committees* that are separately funded and could replace the current "dispute resolution" committees;
- Create real incentives in all applicable Federal Funding Streams, such as Medicaid, Medicaid Waivers, as well as in federal grant programs to insure that children with Co-Occurring Disorders are a priority for services.

For additional information

www.westchestercommunitynetwork.com

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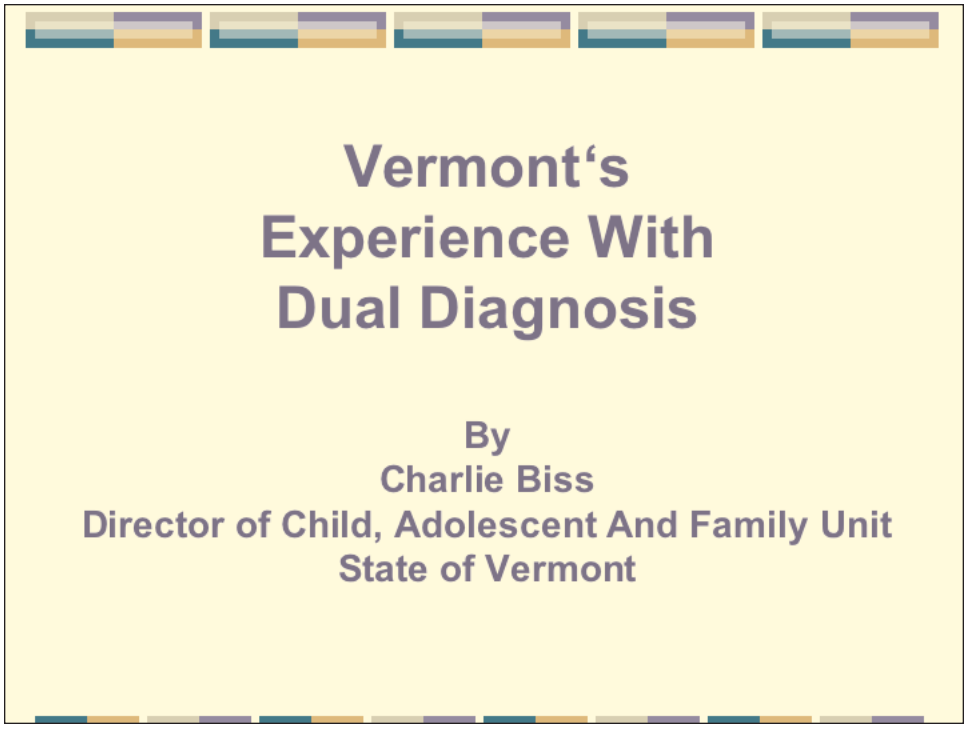
Vermont Department of Health



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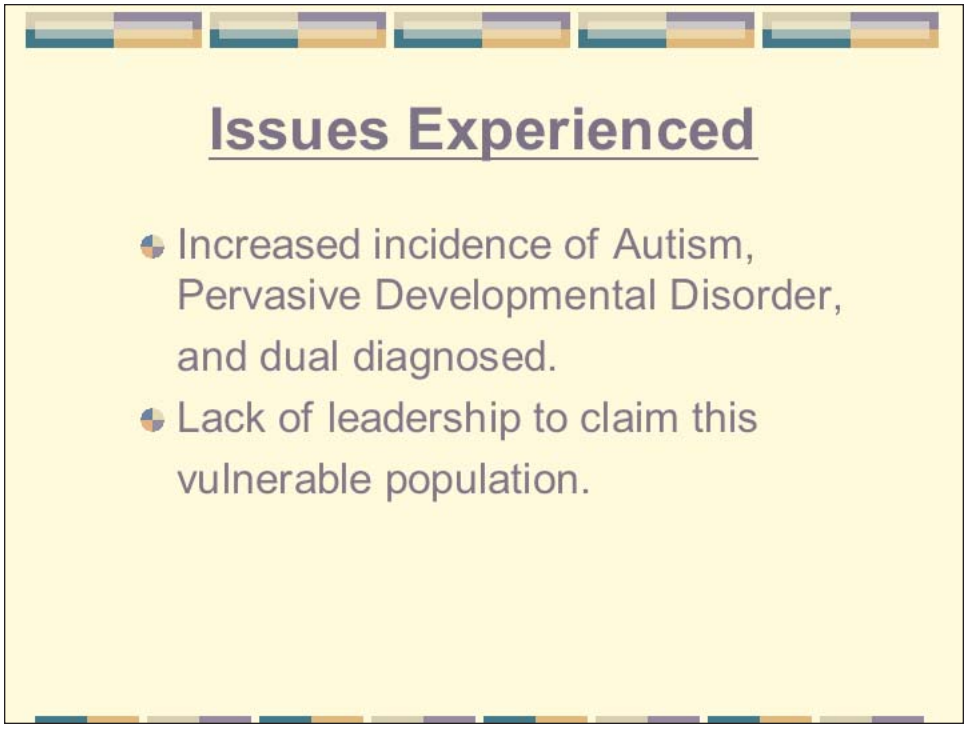

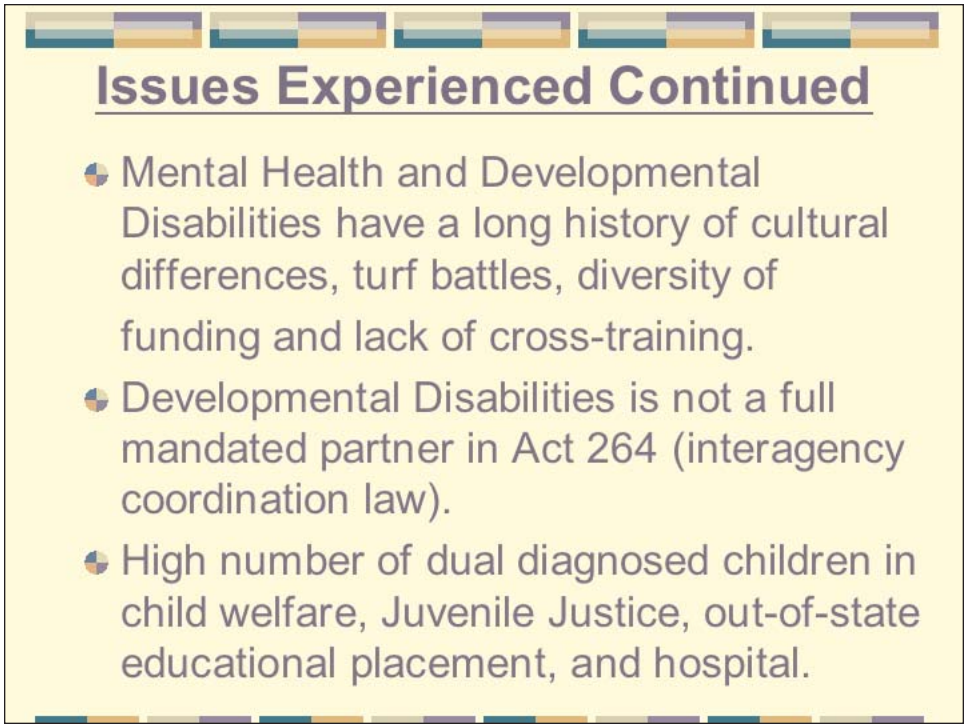

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Issues Experienced Continued

- These children are usually identified at times of significant family and school crises.
- There is a lack of trained professionals to make effective differential diagnoses and to treat and support these children and their families.

Action Taken

- Invited Developmental Disabilities to become part of Act 264.
- Interagency groups at the local and state level discussed the policy and treatment issues for this population and their families were invited to these discussions.

CHARLIE BISS, M.S.W.

Action Taken Continued

- Encouraged treatment teams to develop appropriate plans of care for these children regardless of the funding.
- Discussed the poor outcomes as a result of not serving these children well:
  - inappropriate hospitalization
  - out-of-state placements by school
  - custody relinquishment to child welfare
  - incarceration by Juvenile Justice.

Action Taken Continued

- **Mental Health and Developmental Disabilities jointly applied for and received state funds for children with Pervasive Developmental Disorders.**
- **Mental Health works collaboratively with early childhood professionals (e.g., Part C) and with pediatricians to identify early onset of social/emotional problems.**

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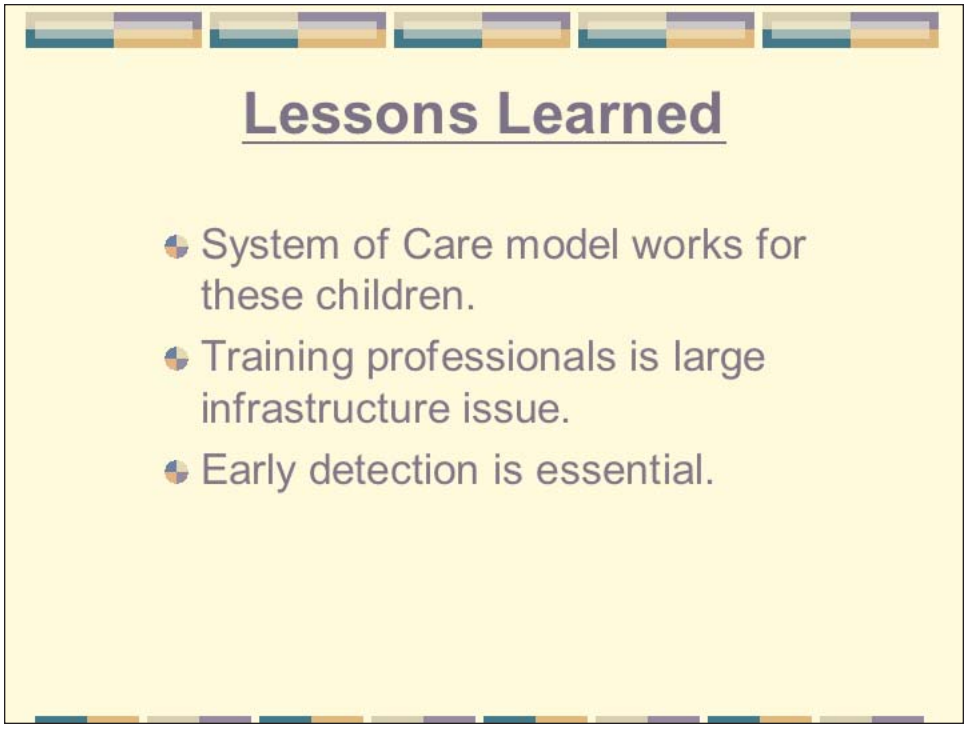

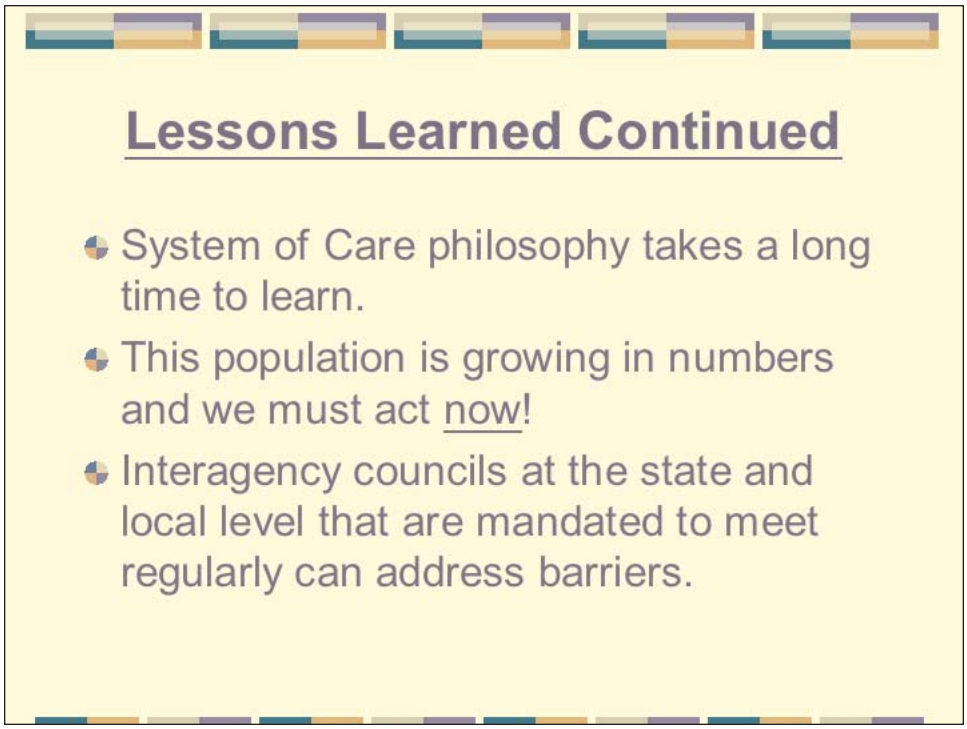

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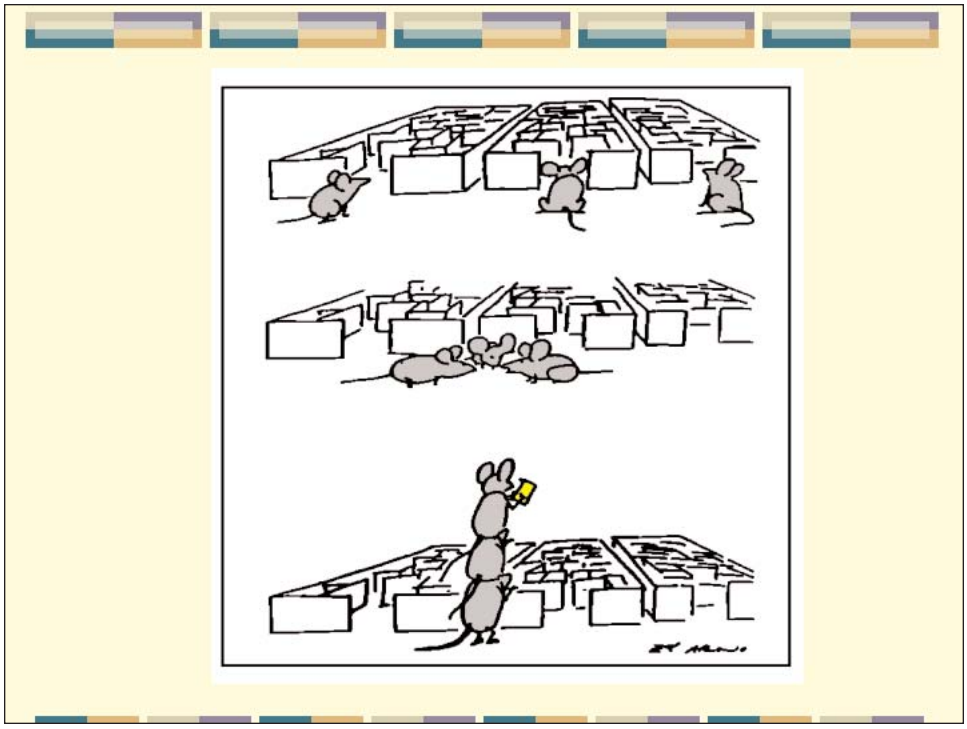

Best Practice

- Interagency collaboration, early detection, a trained workforce and family involvement are essential in providing the effective services and supports to a child with dual diagnosis and their family.

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CHERYLL BOWERS-STEPHENS, M.D., M.B.A.
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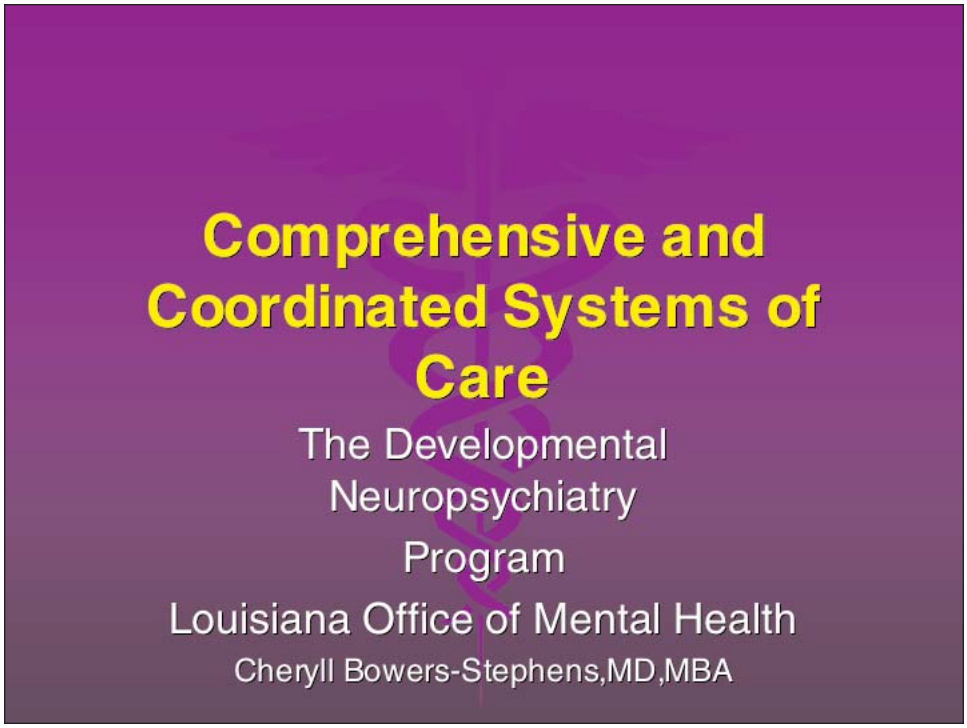

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The Developmental Neuropsychiatry Program (DNP)

- System of Care serving youths who have both a psychiatric illness and a developmental disability
- The program has been in operation for over 10 years
- It was designed for youth that have not responded to traditional mental health and developmental services

History of Program Development

- Youths with Mental Illness and Developmental Disabilities were falling through the cracks and clogging up isolated service systems ill-equipped to address their needs
- Unacceptable given the prevalence: mental illness occurs in a higher percentage of persons with DD (3-6 times the rate in the general population)
- Rates of physical and sexual abuse are higher

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History of Program Development

- Unique Challenge to service systems both with regard to diagnosis and treatment
- Correctly diagnosing MI in persons with DD is difficult
- Mental Health professionals are ill-equipped to make correct diagnosis
- Repeated misdiagnoses resulting in repeated ineffective treatments and ineffective pharmacotherapy

System of Care Overview

- Goal is to break the cycle of multiple hospitalizations and institutionalization by promoting community inclusion.
- Outpatient assertive community treatment program serving ages 2 to 22.
- Inpatient adolescent unit serving ages 13 through 18.
- ICF-MR Waiver Demonstration Project
- Long term follow up

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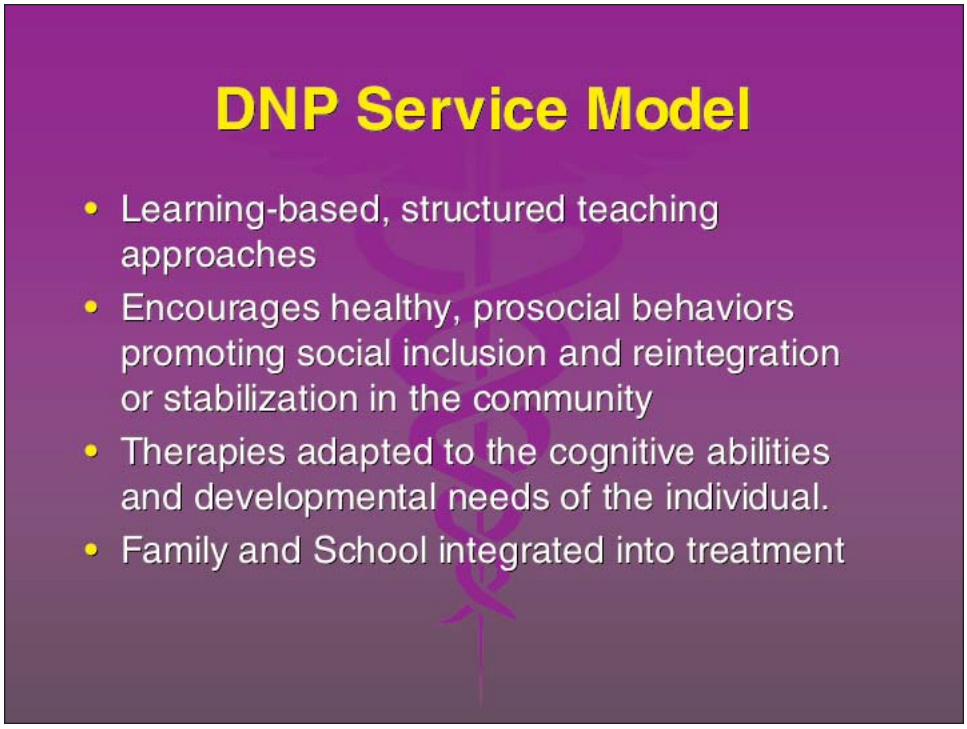

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Evidence Based Practices

- Integration of behavioral and pharmacological interventions
- Functional Analysis and Behavioral Modification(Applied Behavioral Techniques; Cognitive Behavioral Therapy; Classical Behavioral Therapy)
- Continuity of Care
- Modified Linehan Approach (Dialectical Behavioral Therapy)
- Relaxation Training

Prevalence of Psychotropic Usage by Drug Class (Prior to Admission)

Drug Class	Percentage
Neuroleptics	85.0%
Mood Stabilizer	73.5%
Anti-Depressants (non-SSRI)	54.4%
SSRI's	55.8%
Anti-Depressants (combined)	78.2%
Psychostimulant	46.3%
Anxiolytics	24.5%
Anti-Convulsants	16.3%
Anti-Hypertensive	36.1%

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Not Uncommon Errors in Diagnosis

- Psychosis based solely on invalid self-report of auditory hallucinations
- PTSD diagnosed as Psychosis
- PTSD diagnosed as Conduct Disorder
- Bipolar Disorder diagnosed as Conduct Disorder

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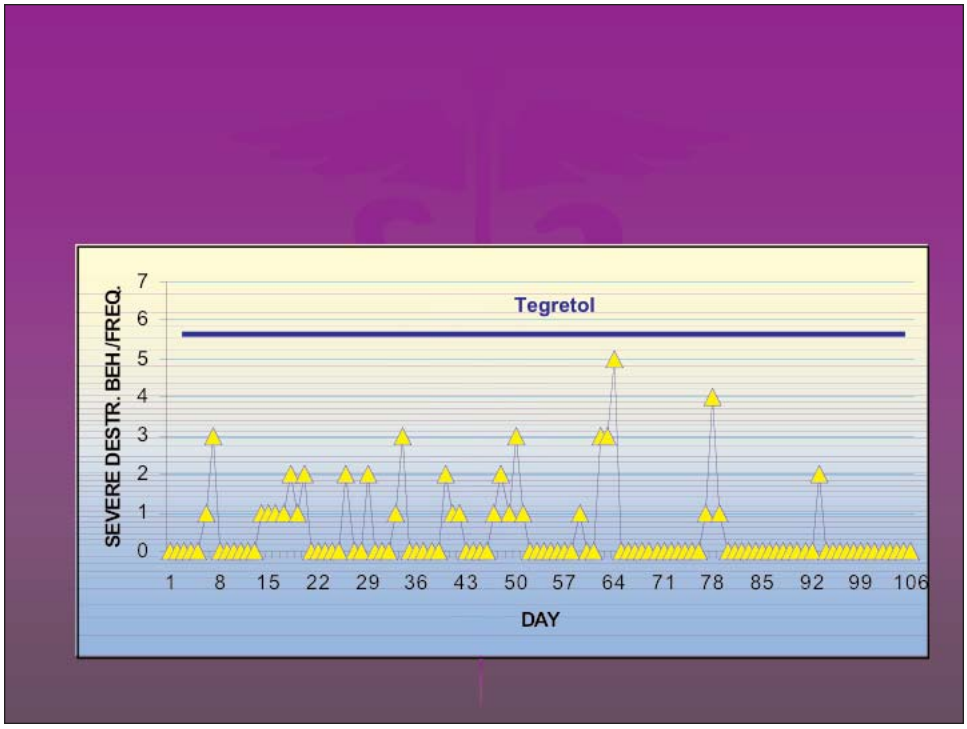

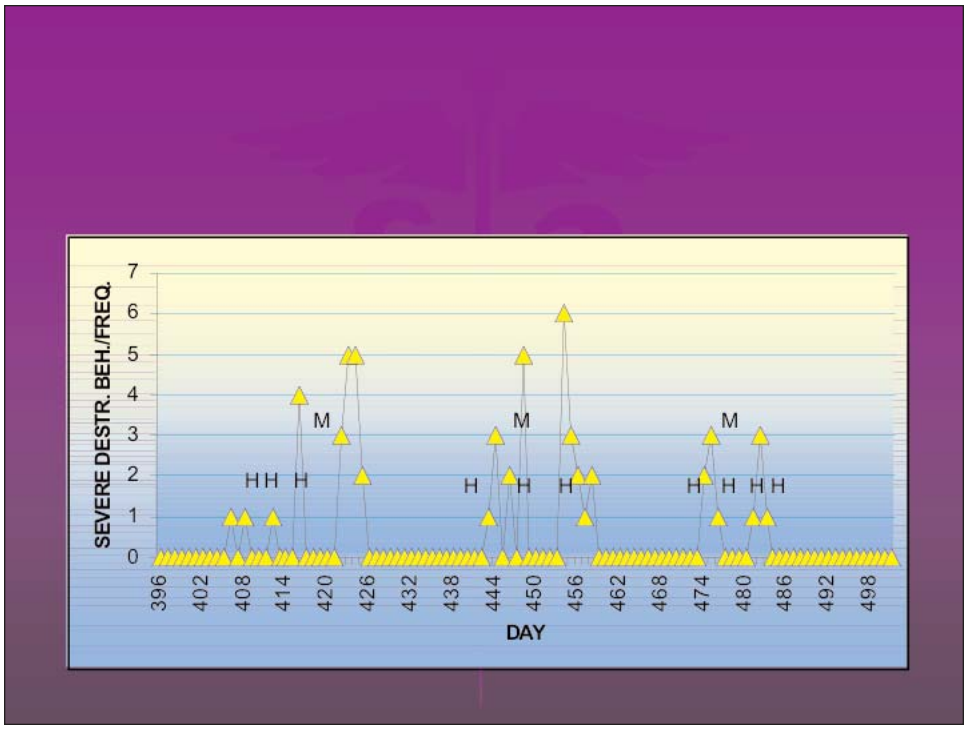

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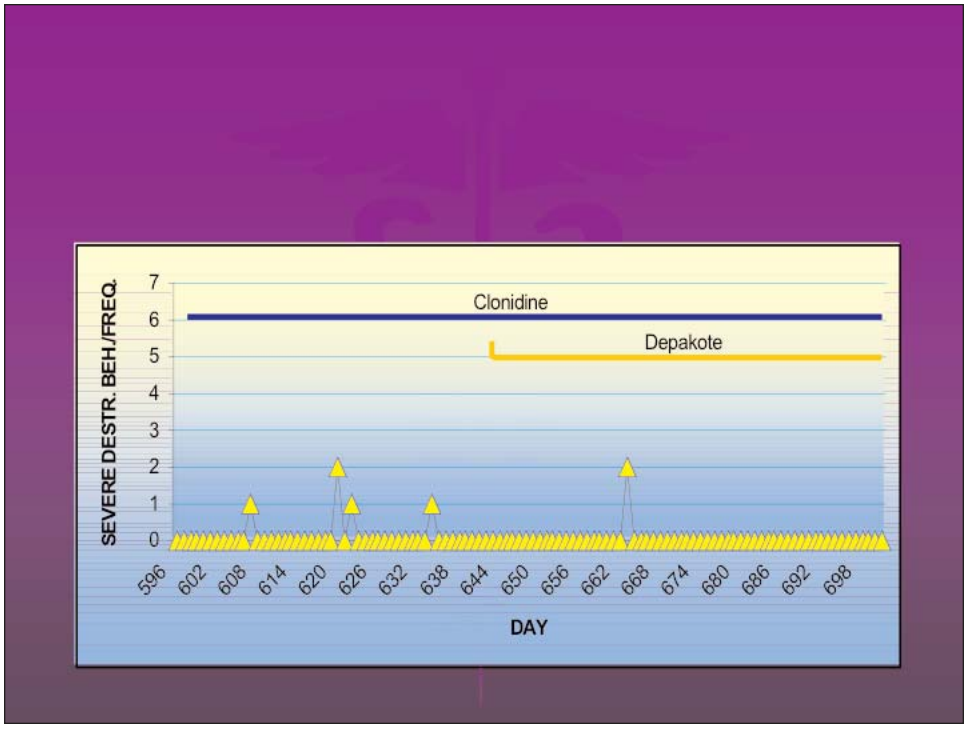

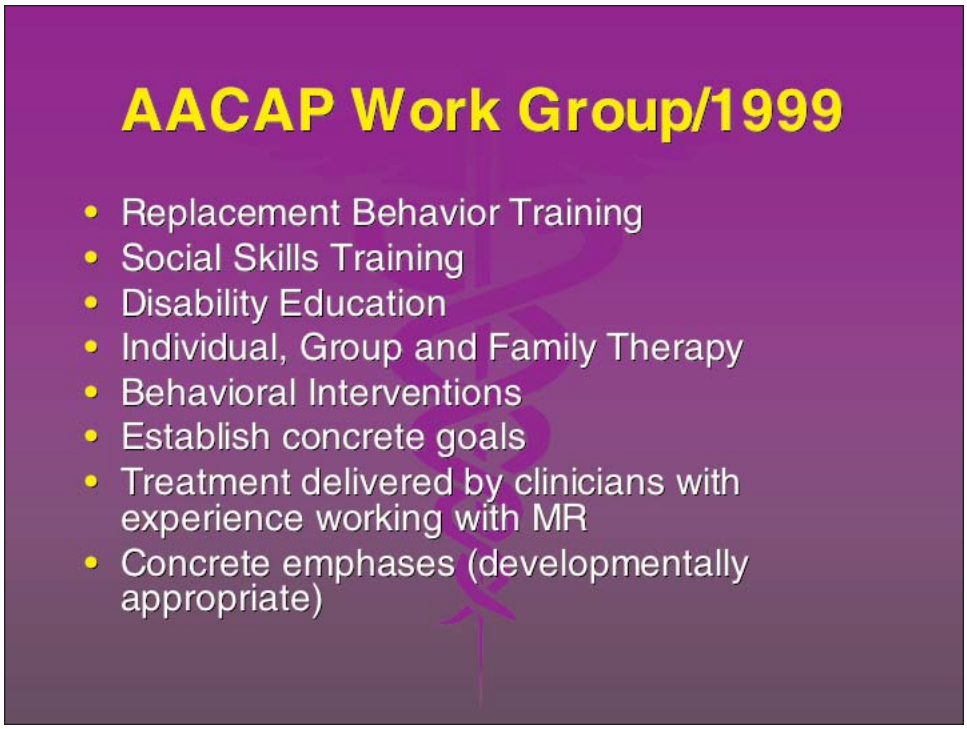

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AJMR – Consensus Guidelines (May 2000)

- Applied Behavioral Techniques
- Cognitive Behavioral Techniques
- Classical Behavior Therapy

Behavioral Treatments of Depression

- Increasing Pos. Activities/Stimulation (Lewinsohn)
  - Increase Fun and Success Experiences
- Operant Approaches
  - Positive Statements
  - Engagement in Activities
  - Social Skills Training
- Cognitive Behavior Therapy
  - Modifications

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MODIFIED DAILY MOOD LOG

Sad Thoughts	Happy Thoughts
Nobody likes me. *I don't have any friends.*	*I guess when I think deep down inside that there are a lot of people who do like me. (Lists them).*
I'm fat and ugly.	*Other people say these things are nice about me.* *My hair, eyes, I'm pretty when I smile my eyes my personality*

Summary/CBT for persons with MR

- Simplify Basic Model of CBT
- Use Simple Explanations
- Use Simple Language
- Teach to Challenge Distorted Thinking
- Teach to Distract Self with Positive Cognitions
- Simplify Task by Refraining from Teaching Categories of Cognitive Distortions

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Behavioral Treatments of Anxiety Disorders

- Phobia Studies
  - Peck (1977) and Jackson (1983)
- Standard Systematic Desensitization
  - Establish Fear Hierarchy
  - Teach SUDS Rating
  - Introduce Counterconditioning Element
  - Introduce Exposure
- Modifications for MR
  - Participant Modeling
  - Reinforced practice
  - In Vivo Exposure

Behavioral Treatments of Anxiety Disorders (cont')

Obsessive Compulsive Disorder

Case Example

Gradual Negotiated Change

Exposure with Response Prevention

Positive R+ (Social/Tangible) of Goal Attainment

Generalization to Home Setting

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Behavioral Treatments of Anxiety Disorders (cont')

Post-Traumatic Stress Disorder

Hamilton (1994) – Managing Acute Distress

1. Relaxation training/Self-calming strategies
2. Removal from triggers
3. Cognitive Distraction

Protocol III

1. Counterconditioning Strategies
2. Imaginal Flooding
3. Planning for Possible Triggers
4. CBT

Borderline Personality Disorder

Linehan – Psychosocial Skills Training for Borderline Personality Disorder

1. Emotion Regulation Skills
2. Interpersonal Effectiveness Skills
3. Distress Tolerance Skills
4. Mindfulness Skills

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AACAP Work Group Commentary (1999)

- Some clinicians target symptom suppression without regard for habilitative functioning
- Informed consent often overlooked
- Medication often is not integrated as part of comprehensive treatment plans
- Medications often don't match diagnosis
- Polypharmacy is overused
- There is often no active monitoring for side effects

Outcomes

- 207 patients served
- 184 served inpatient
- 60 served outpatient
- 23 outpatient only
- 123 inpatient only
- 37 both inpatient and outpatient

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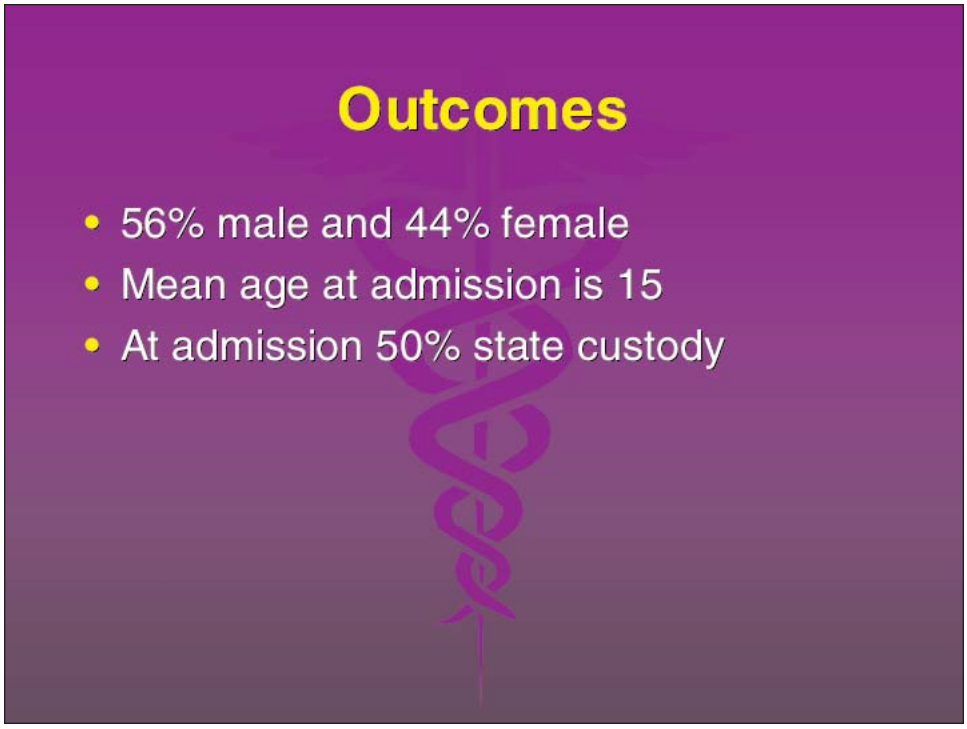

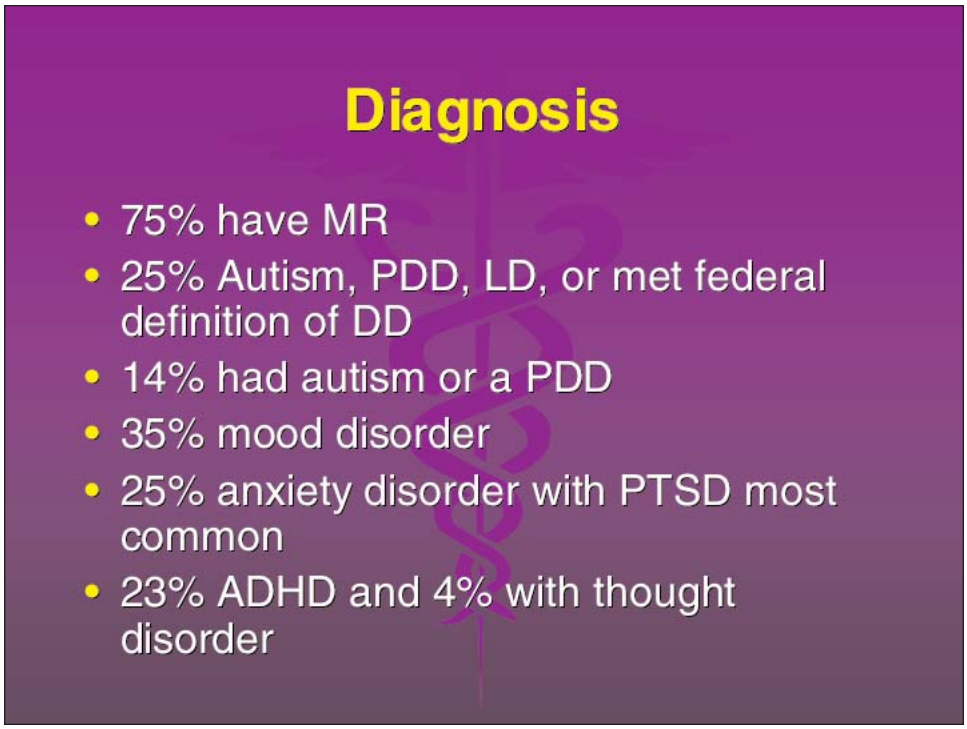

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Level of Care	Initial (177)	Current (131)
Supported/IN	6 (3%)	27 (21%)
Parent/Family	86 (49%)	51 (39%)
Foster Family	25 (14%)	5 (4%)
Group Home	34 (19%)	21 (16%)
Residential	6 (3%)	6 (5%)
Hospital	6 (3%)	5 (4%)
Detention	3 (2%)	4 (3%)
ICF-MR	7 (4%)	11 (8%)
Eloped	4 (2%)	0
Deceased	0	1 (1%)

Outcomes

- 86% in community/non-institutional settings
- 67% no re-hospitalization
- 74% have not served time in a correctional facility
- 88% have not been admitted to an ICF-MR
- 50% have had none of the above

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Juvenile Justice Involvement in DNP Youth

147 INPATIENTS	Pre-Treatment	Post-Treatment
Legal Involvement	57%	36%
Arrests	46%	26%

Mental Health Treatment can Reduce Arrest Rates in this Population

Post treatment 90% of these youth had either no jail time or no jail time less than 30 days.

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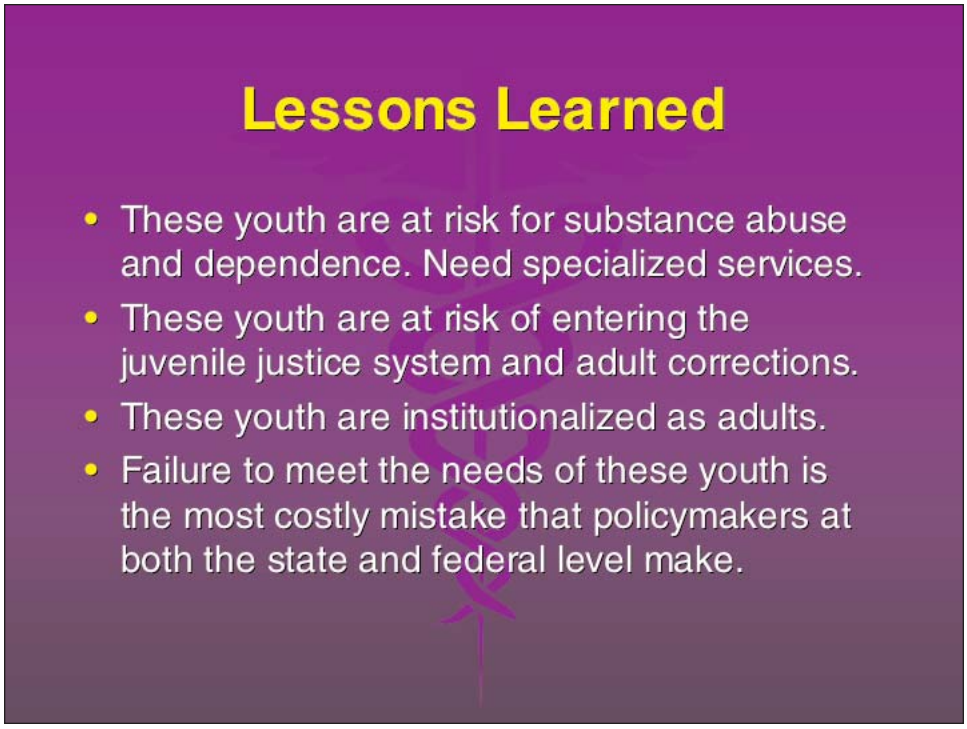

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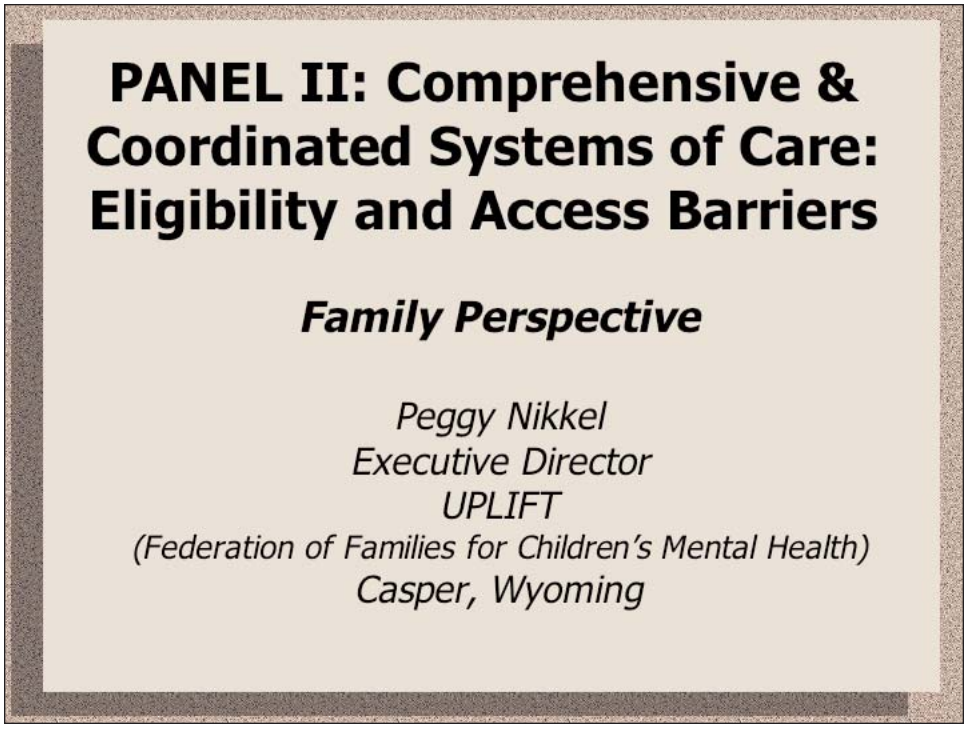

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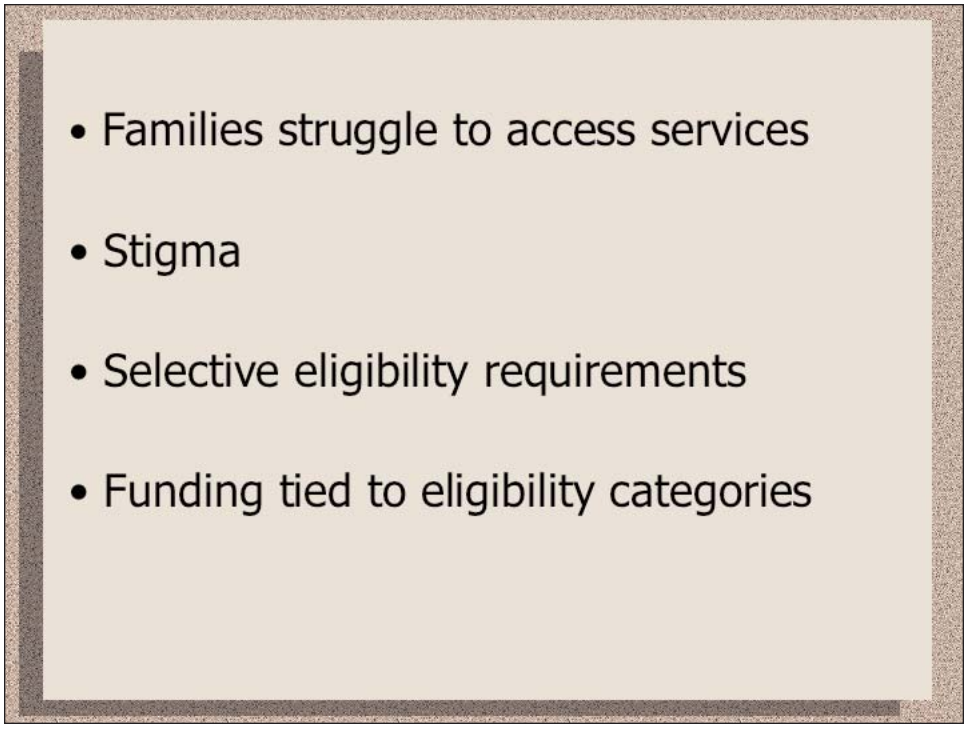
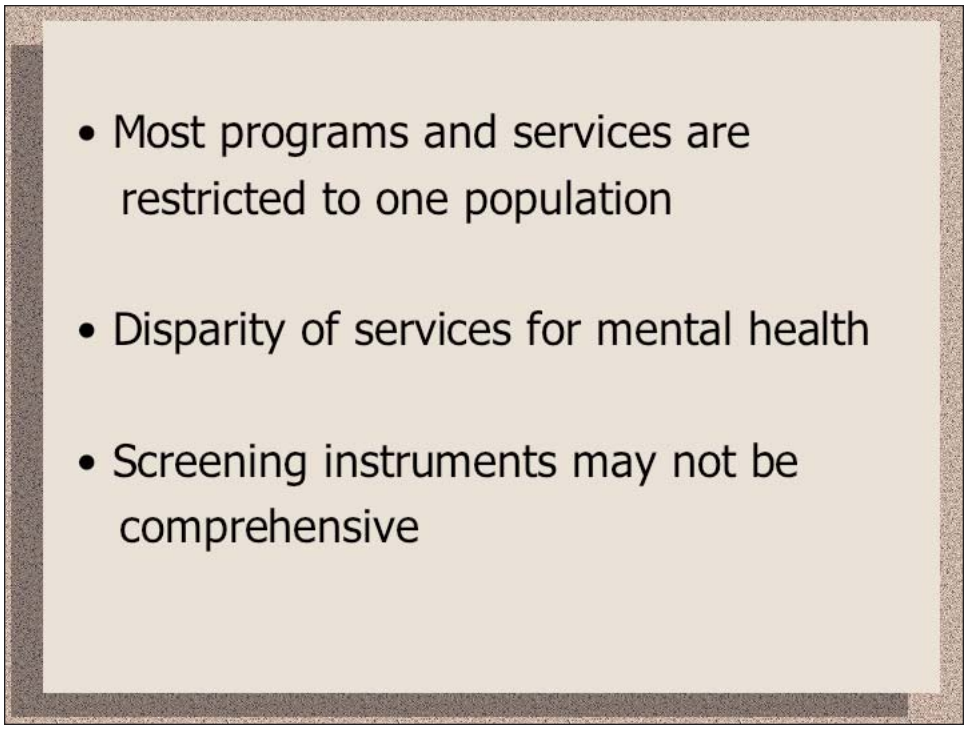




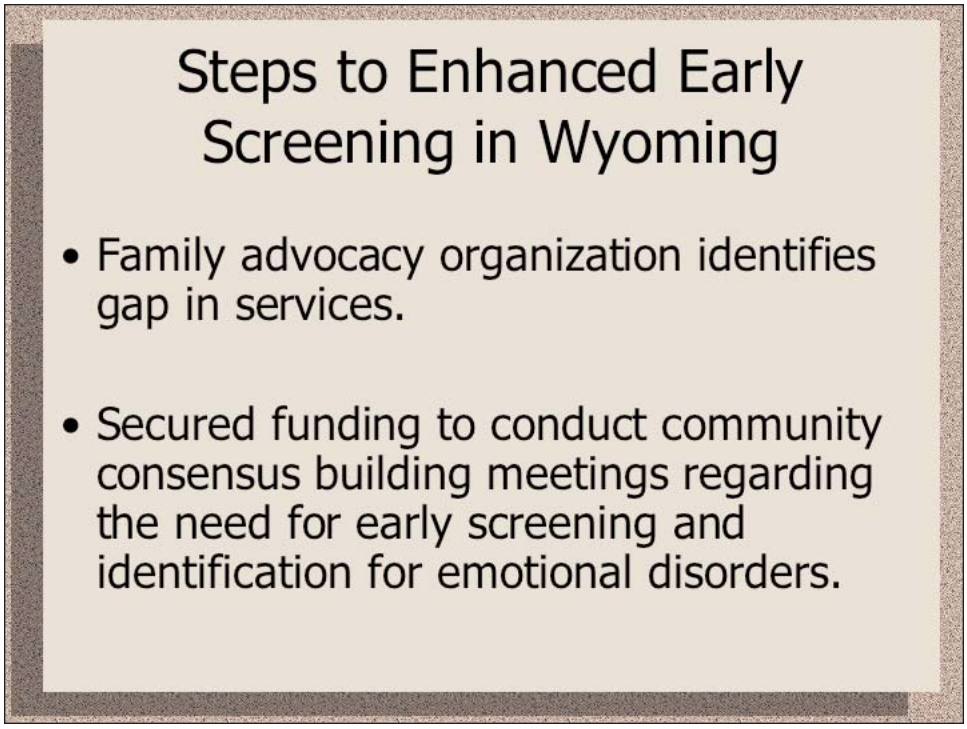
PEGGY NIKKEL

- Lack of adequate training for service providers
- Lack of coordinated treatment team approach
- Families have to find the services and piece them together

Lack of consistent early screening and intervention in Wyoming led to the development of UPLIFT's

Wyoming Early Start Program

PEGGY NIKKEL



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- Developed Wyoming trainers to train early childhood providers in the use of research-based early screening and intervention models.
- Collaborated with existing early childhood state initiatives to include strong component in social and emotional development.

- Assembled funding partners to plan and implement annual statewide children's mental health conference with a focus on early childhood.
- All Wyoming child development centers and at-risk preschool programs now receive training in early screening and intervention.

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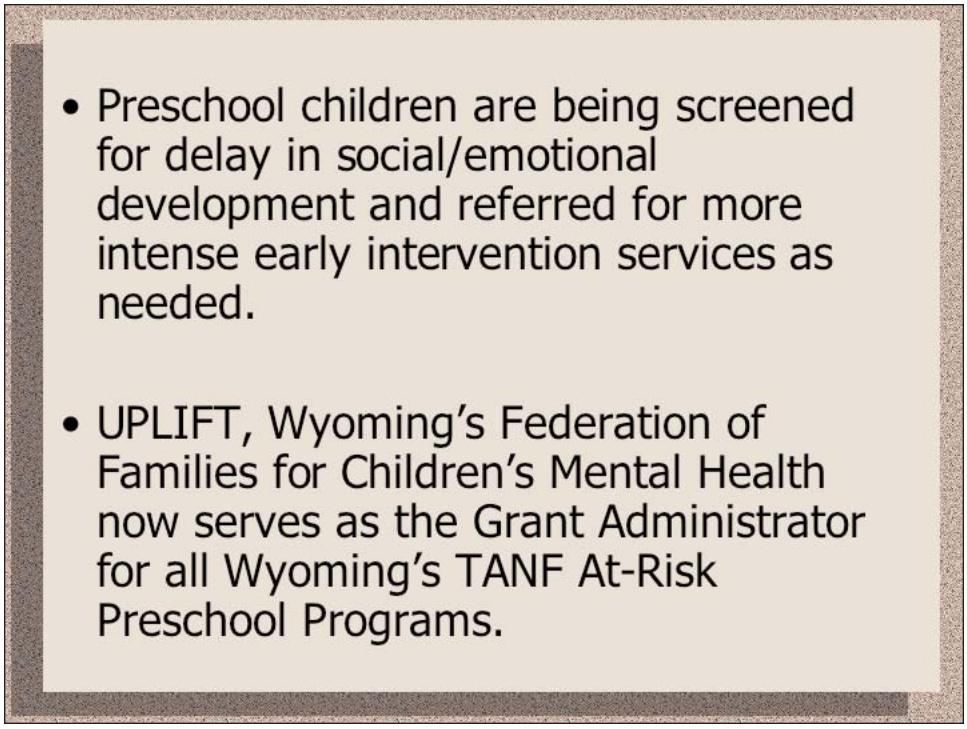

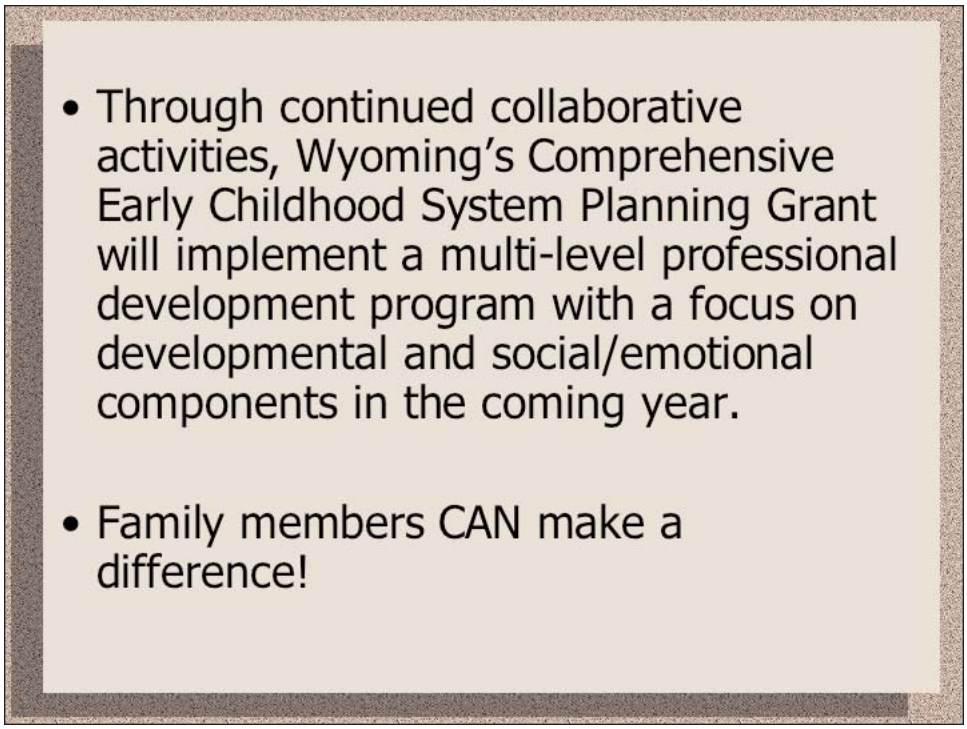

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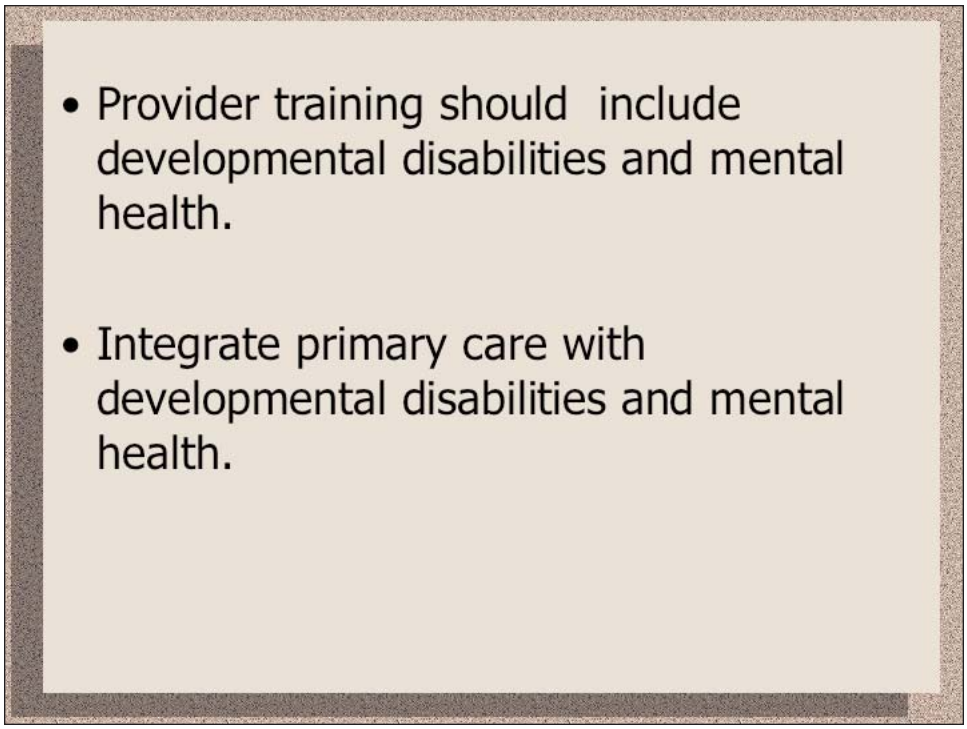

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UPLIFT
Promoting the Emotional Health and Well-Being of Wyoming Children and Families

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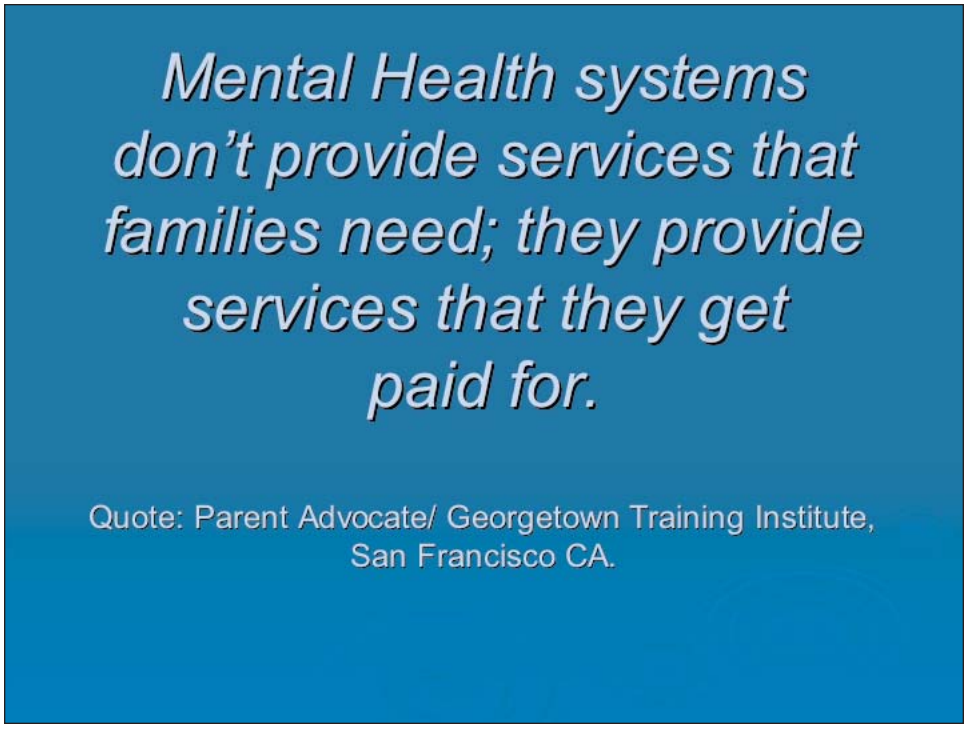

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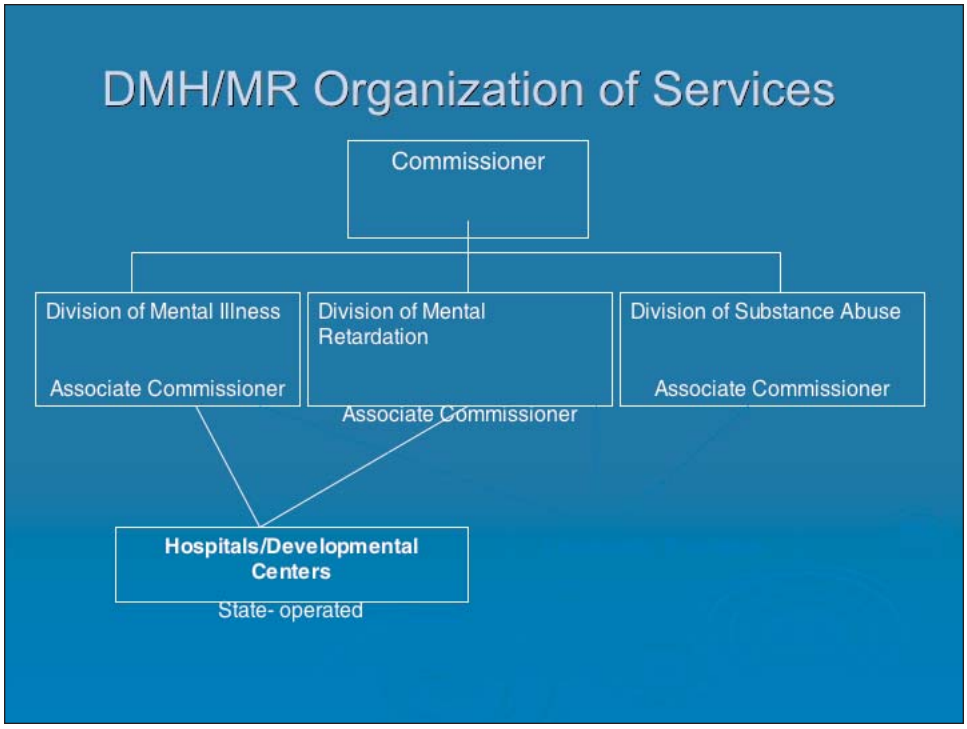

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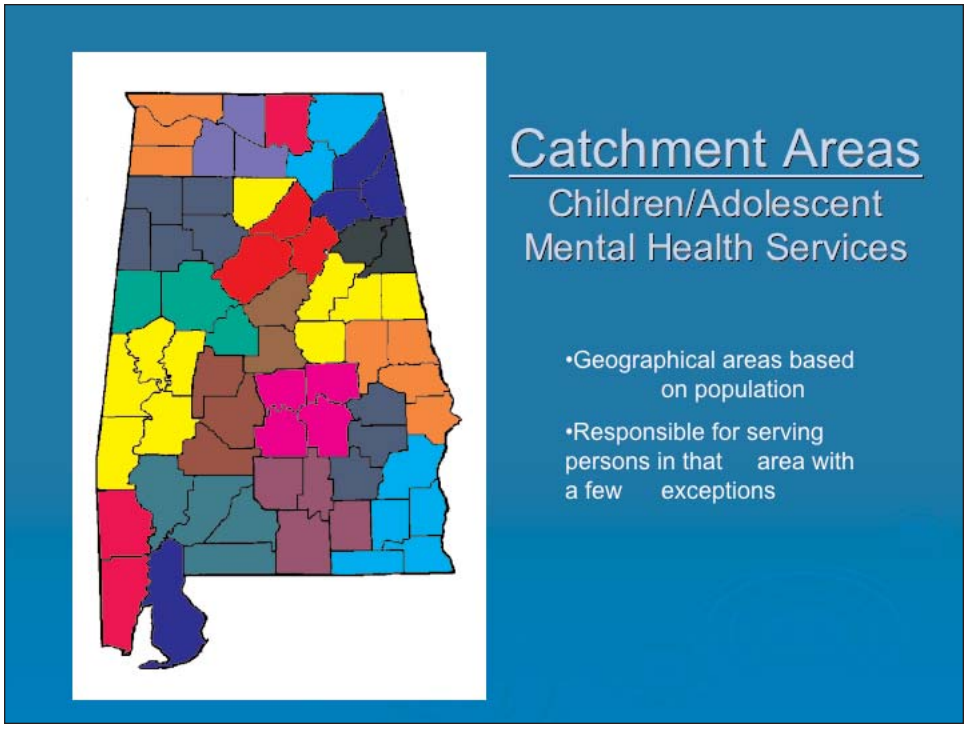
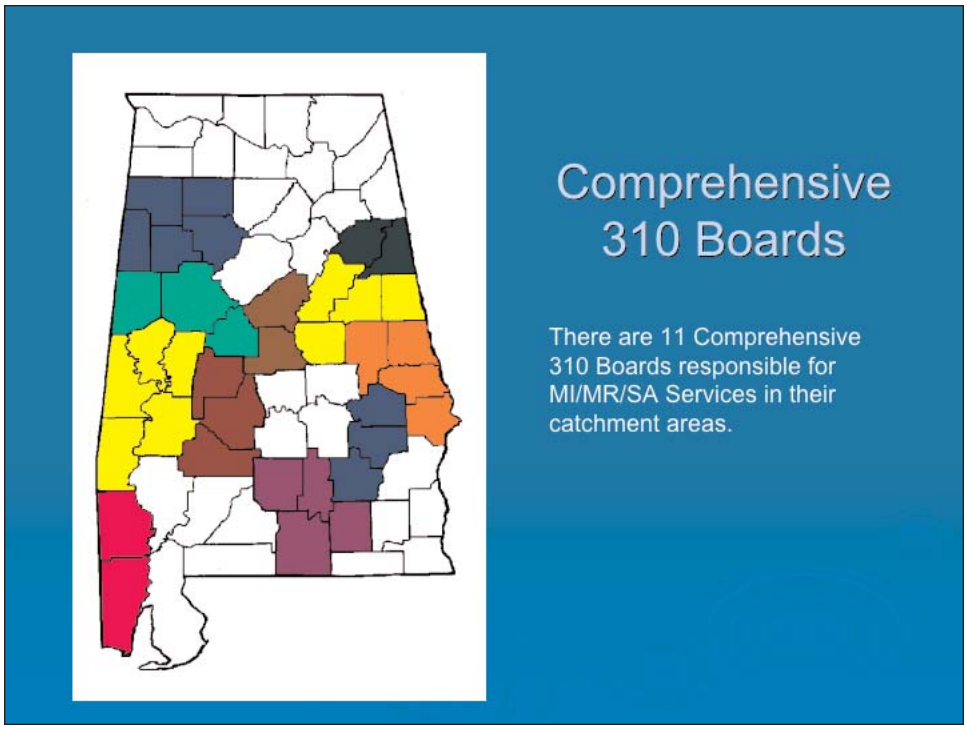
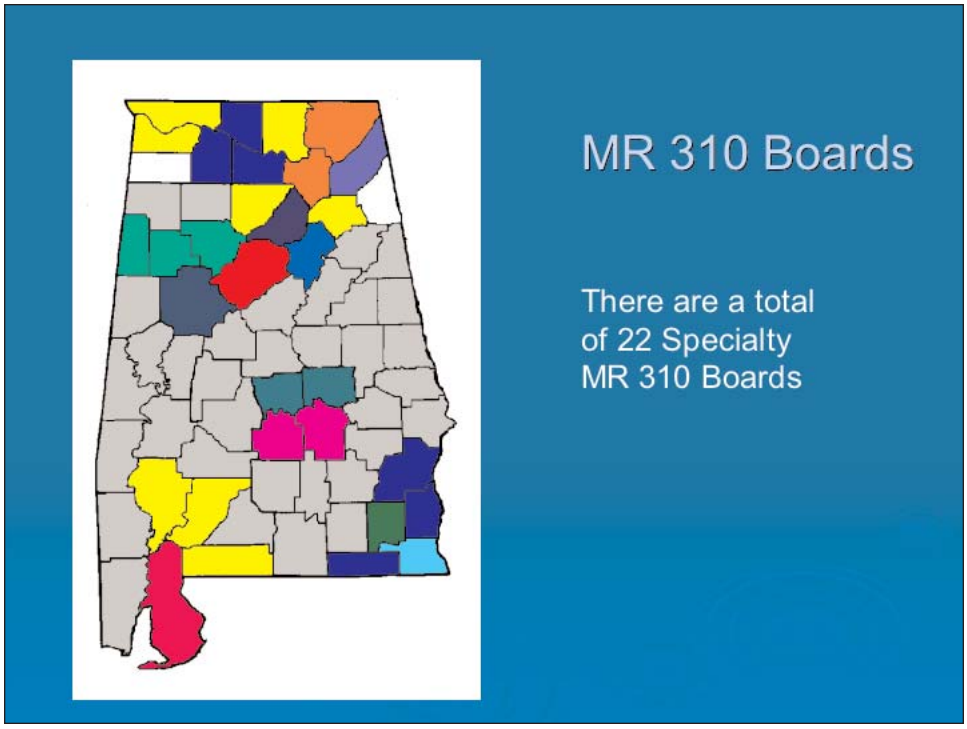
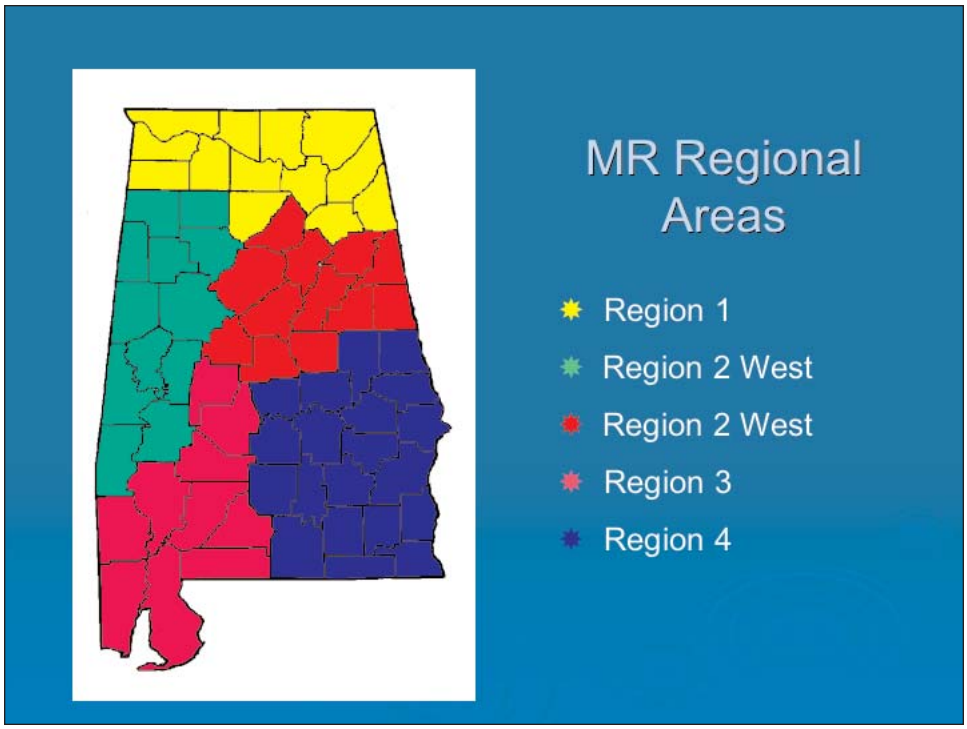




STEVEN LAFRENIERE, M.S.





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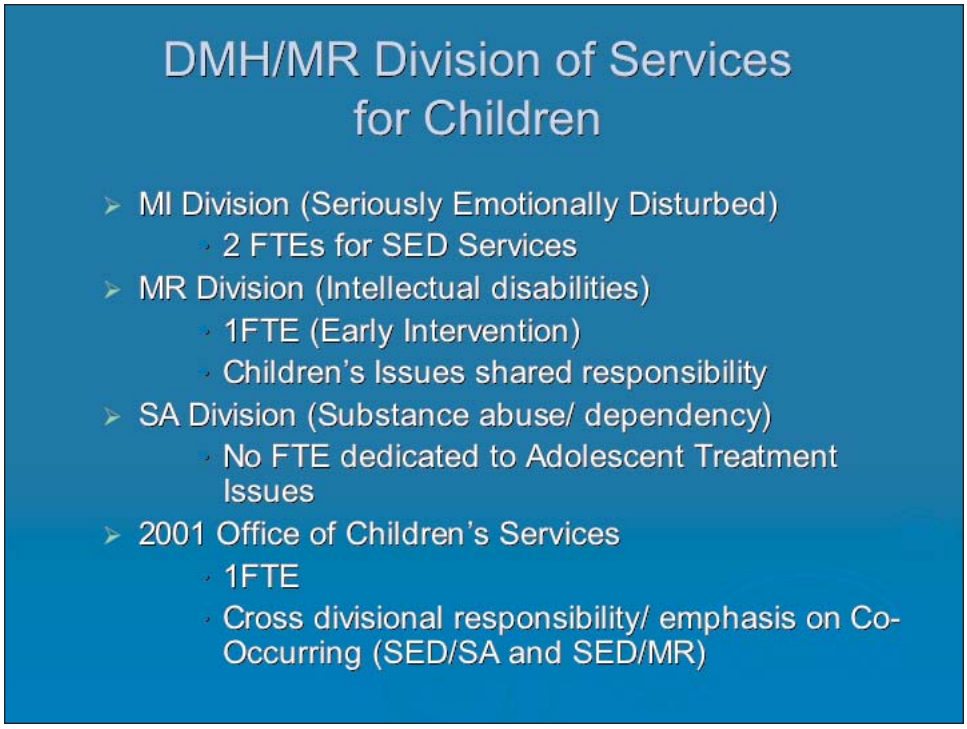

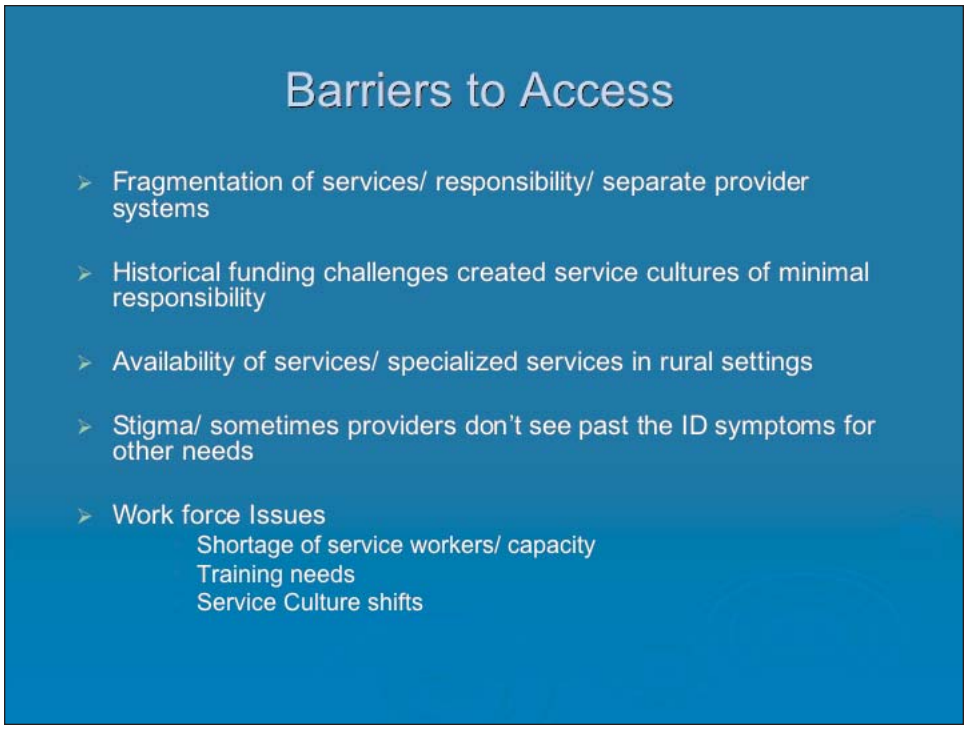

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Barriers to Access Cont.

- Cross-certification of programs
  (Is it MR or MI? -sometimes tied to funding sources)
- Appropriateness of Services
  - Services delivery orientation creates different expectations
  - Cognitive capacity to participate in certain programs (IOP, In-home, residential)
  - Services Structure (O.P. 1 or 2x per month may not be intense enough) More info needed on Best Practices/ especially with this target group
  - Medication issues can be complicated
  - Lack of community resources/Residential services may not be specialized/leads to unsuccessful completion of programs/ longer LOS

Barriers to Eligibility

- State funds / most MR state funds support waiver services/ waivers not easily accessible
- Eligibility determined by what the professional determines as “primary issue”
- Collaboration between multiple systems not always reimbursed (case management)
- MR service system adult focused/ Waiting List

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Barriers to Eligibility cont.

- Some Mental Health services have been historically unavailable to youth with ID, especially intensive in-home and residential type services.
- Barriers to eligible services in school or community can lead in involvement with juvenile justice system

2000 Children's Task Force: Recommendations to Alabama DMH/MR

- 37 stakeholders (child-serving agencies, parents & advocates) recommended:
  - Priority given to children with multiple disabilities & other specialized treatment needs "Gap Kids"
  - Tobacco Settlement/Children First funding will not supplant current funding
  - Entry into the DMH/MR service system should be a single point of contact

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Task Force further recommended:

- Pursue greater collaboration with other agencies to meet the needs children
- Priority given to community-based services
- **C**onsolidate MH/MR children's services into a single organizational unit reporting directly to the Commissioner.

Promising Initiatives in Alabama for Children with ID and SED or SA needs

- Multiple Needs Child Legislation 1993
  - 4 mandated agencies (Mental Health/ Child Welfare/ Juvenile justice and Education)
  - Eligibility (need services of two or more agencies and at risk for out-of-home placement)
  - *Braided funding*
- Children's Task Force of 2000 Enhancement and development of services for "Gap Kids"
  - Establishment of Children's Office/ Director with responsibilities for this population
  - In-home teams
  - Crisis evaluation/ respite

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Promising Initiatives cont.

- OUR Kids Initiative
  - Collaboration with Mental Health/ Child Welfare/ and Juvenile Justice to jointly fund community services for youth whose needs cross agency jurisdiction
  - Each service can serve children with ID and SED.
  - *Pooled Funding*
- Mental Health Juvenile Court Liaisons
  - 22 community mental health clinicians/ youth involved with juvenile justice and have MH/ SA/ or MR needs
- Co-Occurring (MH/SA and Juvenile Justice) Pilot Project for screening/assessment of youth and referral to evidence-based interventions
  - *Pooled funding*

Recommendations

- Follow the momentum generated by Co-Occurring (MH/SA) initiatives when creating new service paradigms and integrated models of care (State & Federal)

  What is the primary diagnosis/issue, may not be the best question for children.

- Federal grant initiatives to highlight or target this population to build capacity as well as provide services/ systems need new competencies

- Advocate for federal incentives to have professionals enter front-line child serving mental health fields

  (i.e. student loan relief)

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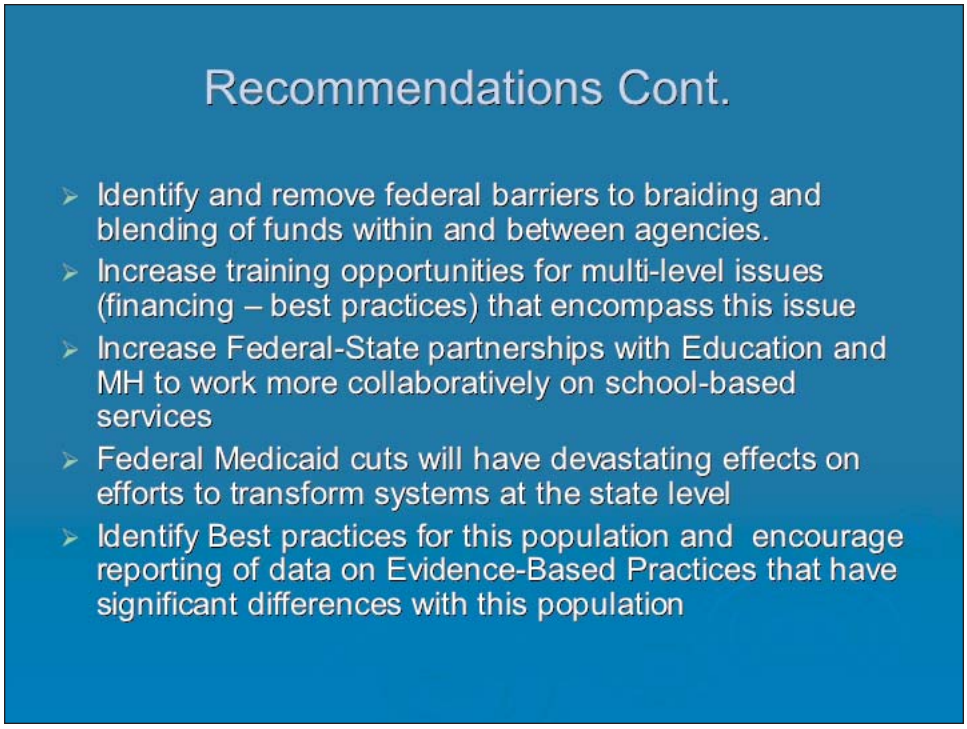

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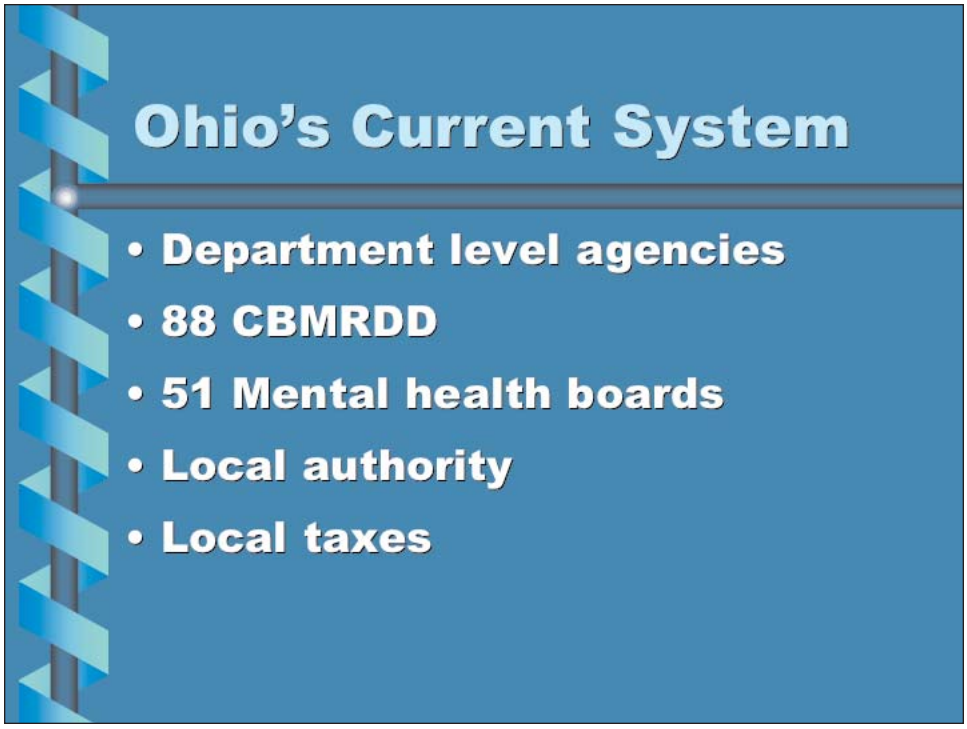

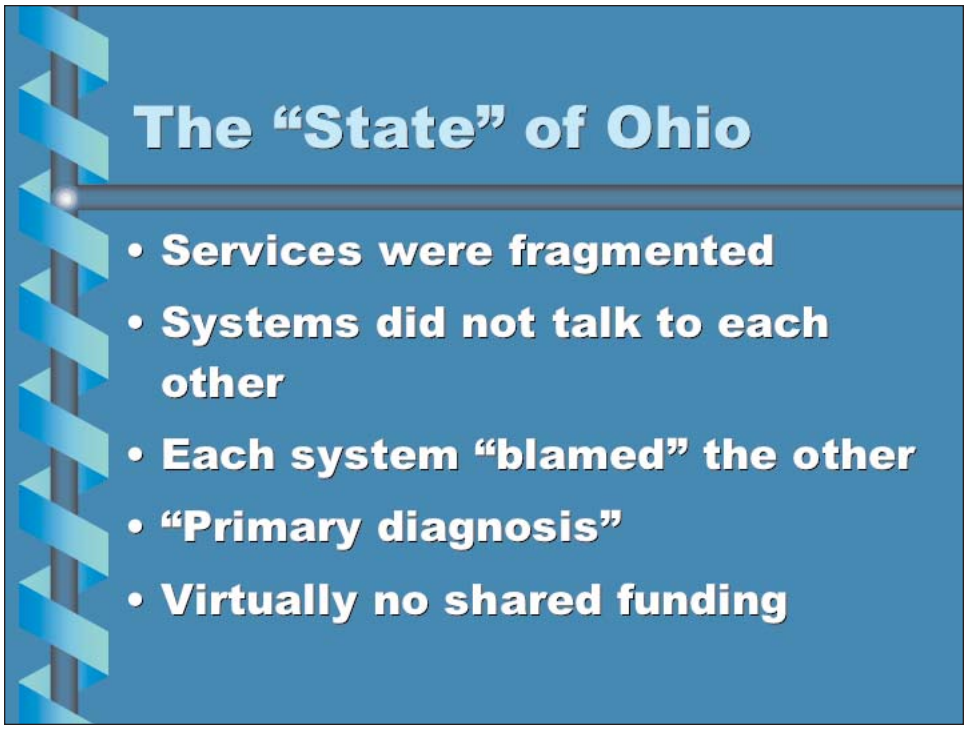

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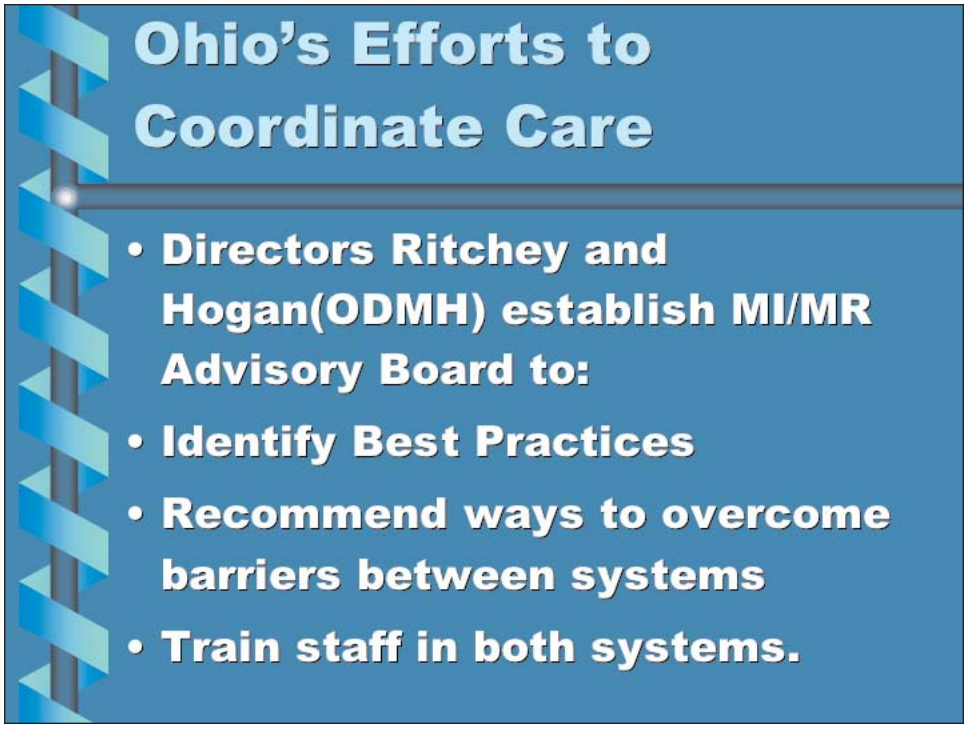

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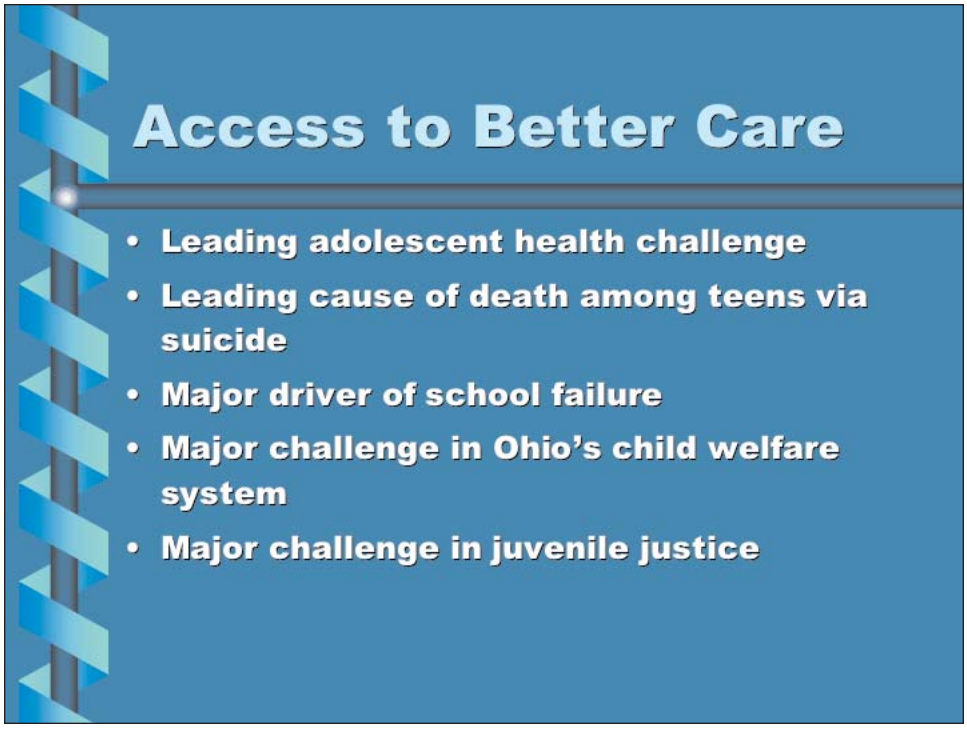

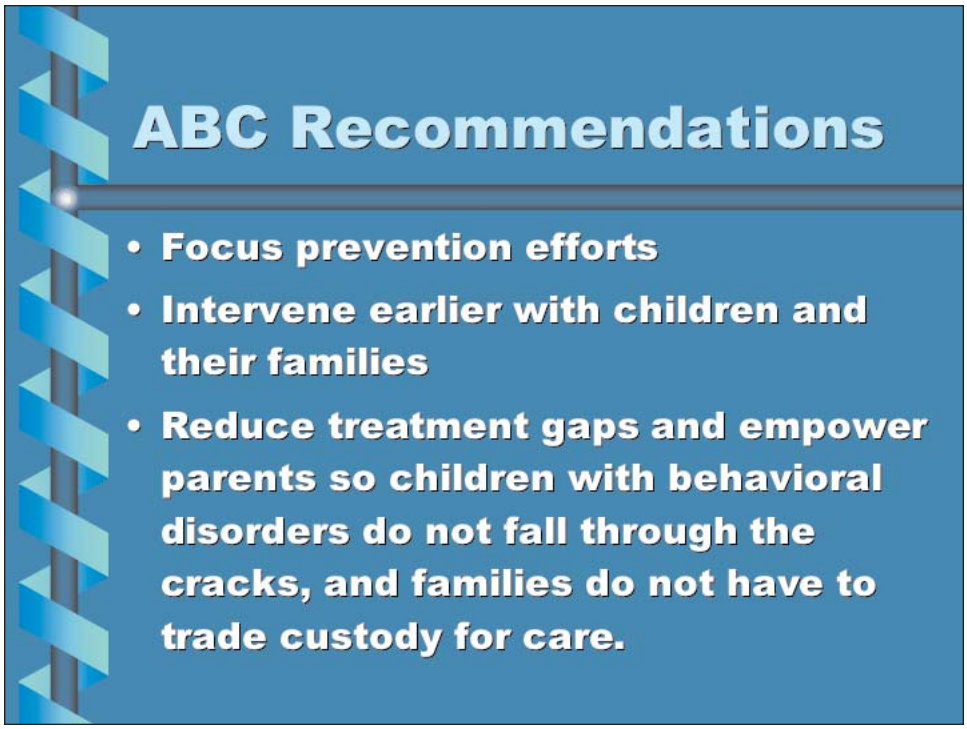

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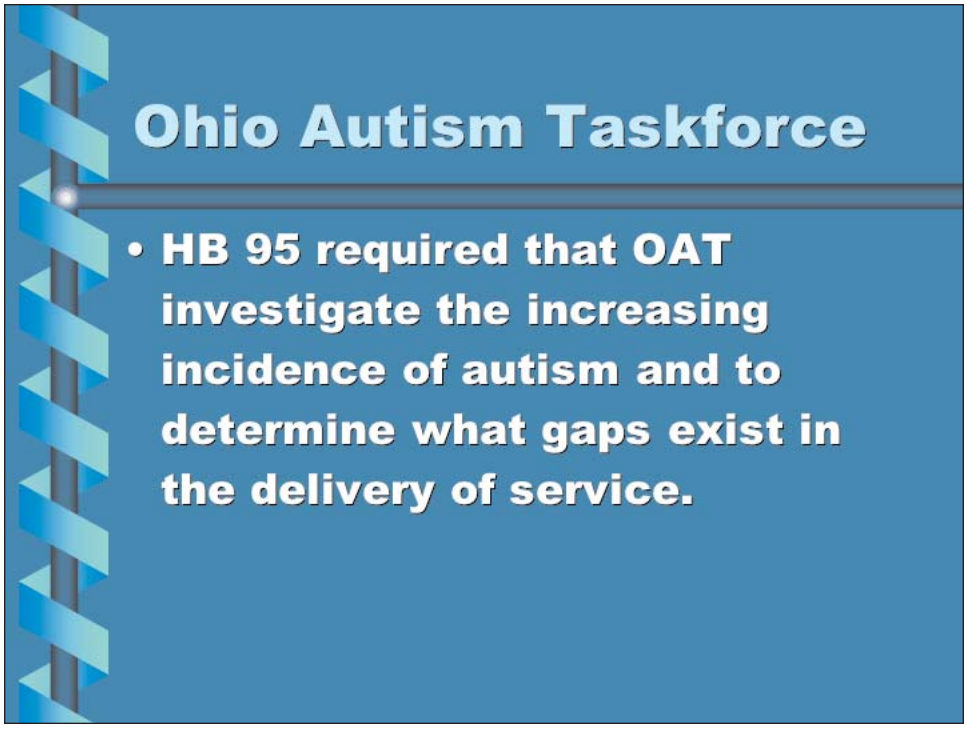

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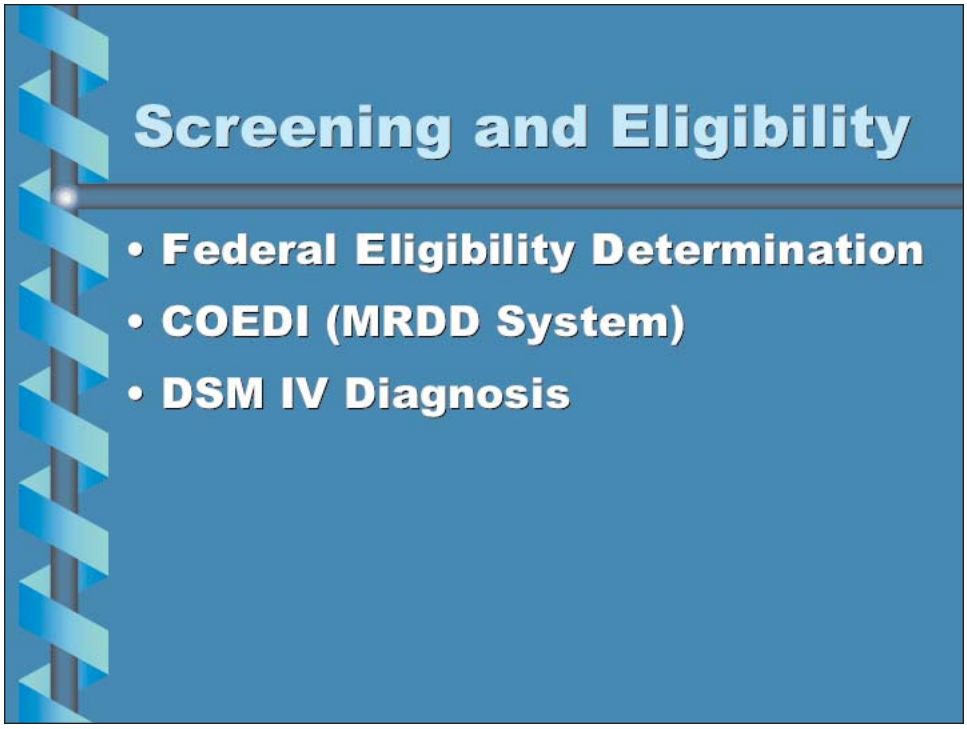

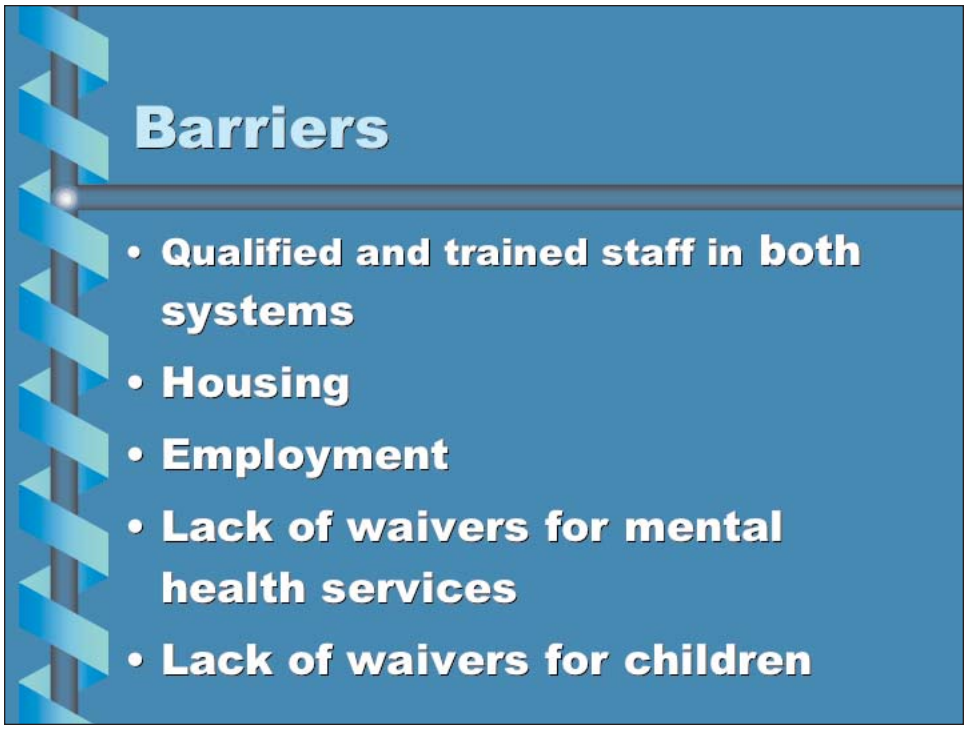

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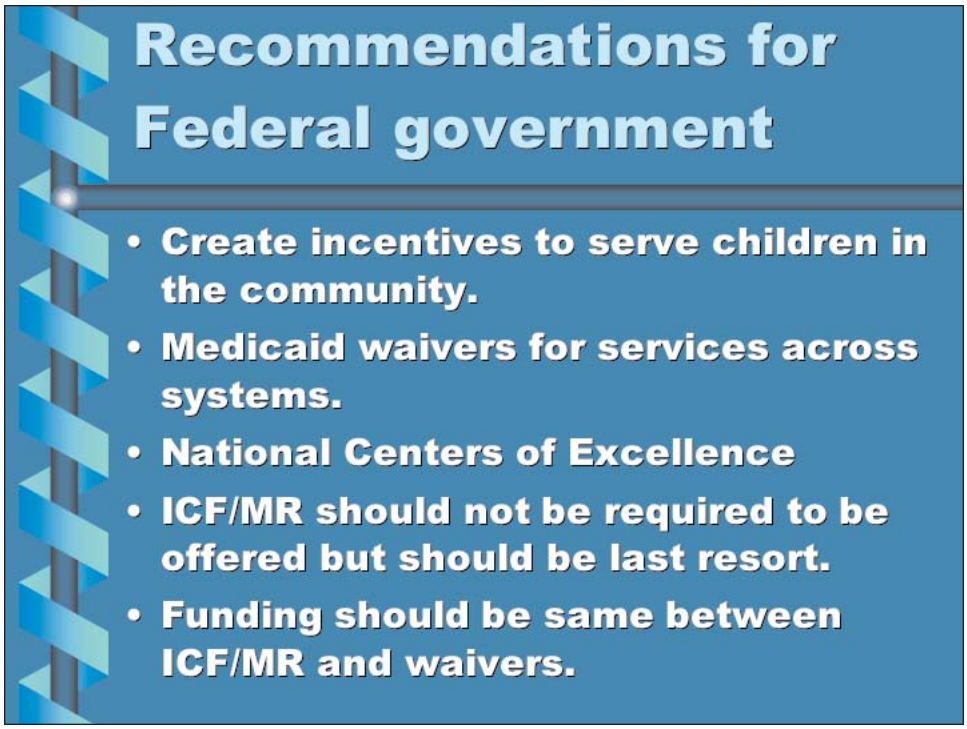

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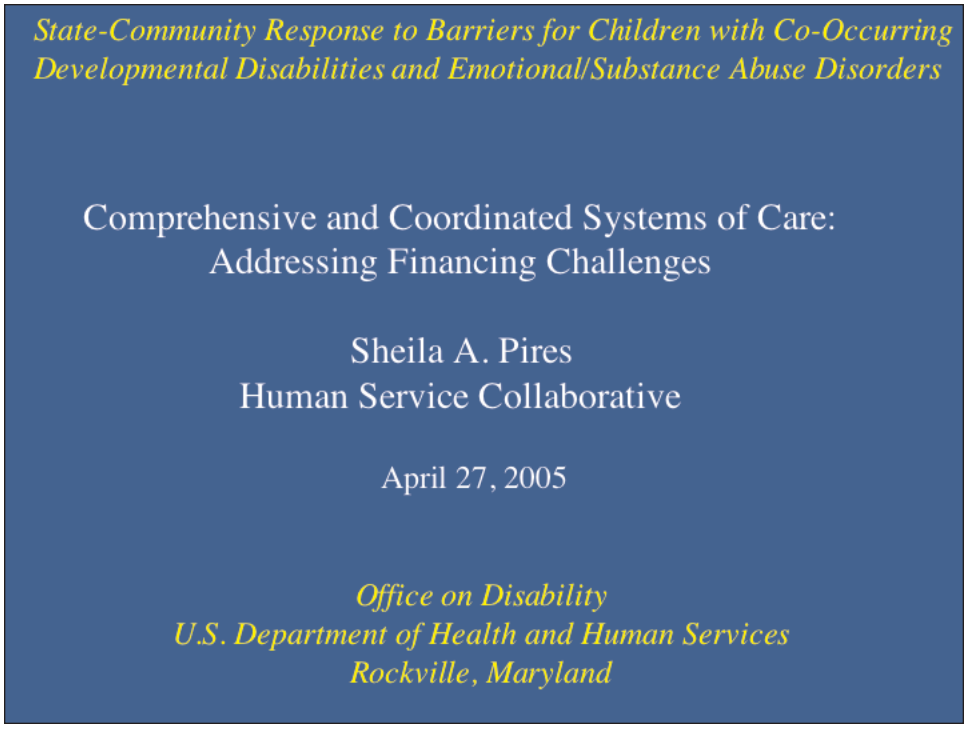

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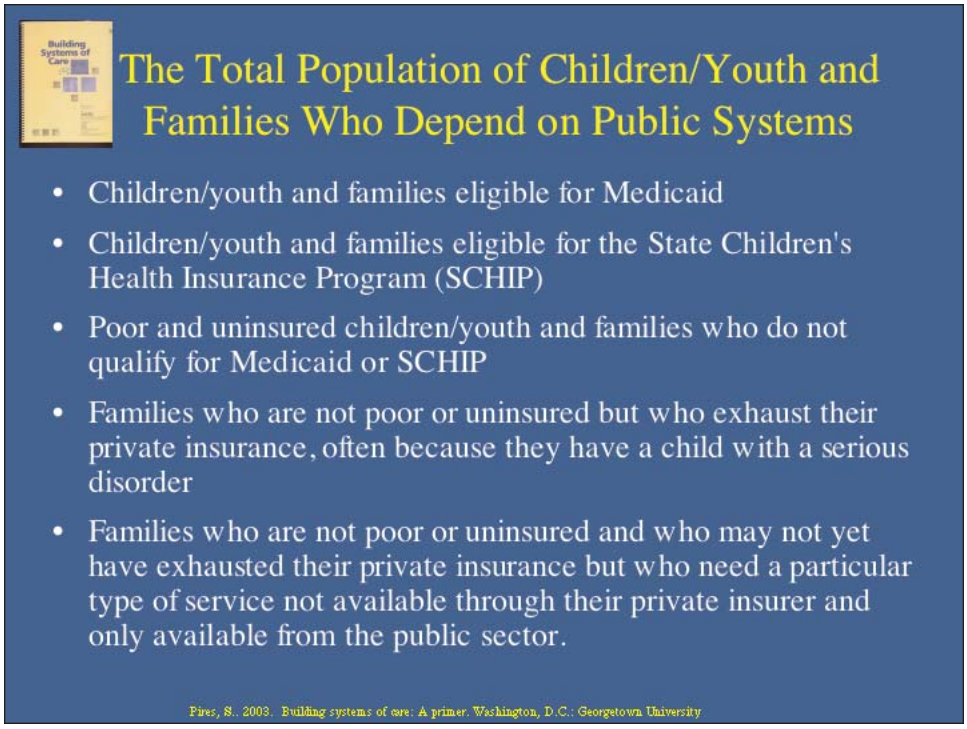

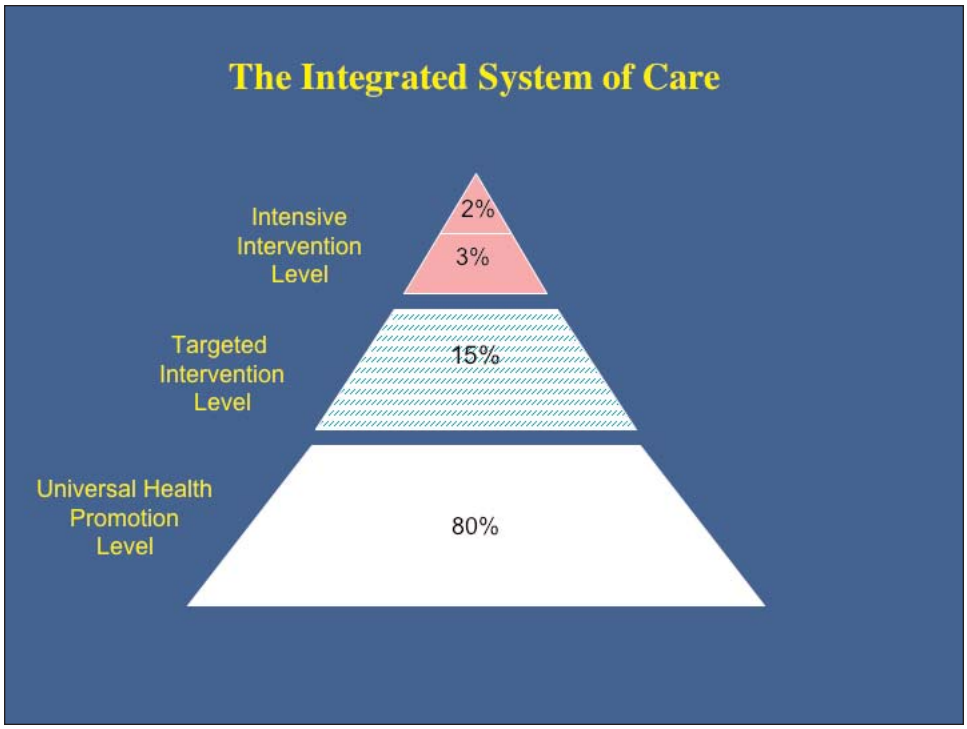

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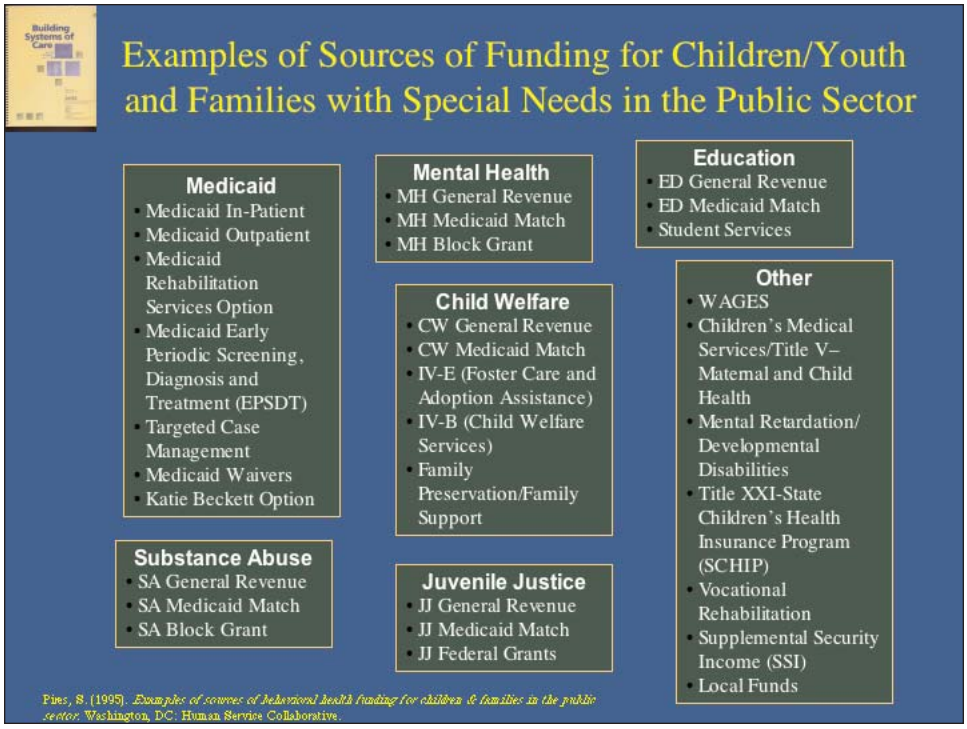

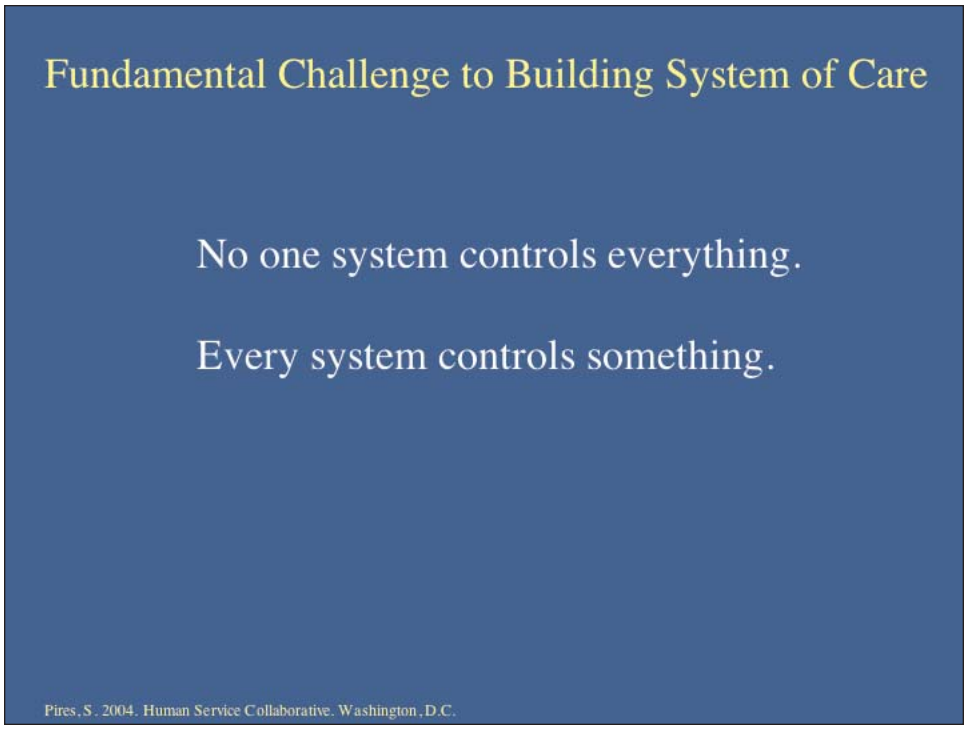

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Examples of Medicaid Promise/Reality

EPSDT
- Broadest entitlement
- Cost concerns so states use various ways to control access through EPSDT

Home and Community-Based Waivers
- Flexibility, broader coverage, waiver of income limits and comparability
- Alternative to hospital-level of care but RTC may be the issue
- Cost and management concerns so limited to certain number

Targeted Case Management
- Can be targeted to high need populations (e.g., co-occurring)
- Not sufficient without other services
- Administrative rulings from CMS?

Some Medicaid Challenges Relevant to Children with Co-Occurring Disorders and Their Families

- Service definitions, esp. for home and community-based
- 15-minute billing increments vs. case rates, esp. for evidence-based services
- Billing for interagency coordination
- Billing for team meetings
- Billing for services to family (as opposed to identified child)
- Billing for non traditional services and supports
- Administrative rulings (e.g., coverage of non-psychiatric medical services in psychiatric hospitals under Psych Under 21 Option)
- States/localities must generate match and manage costs
- Not every child is eligible for Medicaid

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Lots of Medicaid "Urban Legends" But If Something Exists Somewhere, It's Possible Elsewhere

Covering Parents as Care Managers: KN, NJ

Covering Respite in Medicaid FFS: NY

Covering Wraparound Team Process: NE

Covering Non Traditional Services (i.e. traditional Native healers): AZ

Covering Independent Living Services: SC

Diversity of CMHS Grant Sites Funding

SOURCE	SYSTEM	DESCRIPTION
Federal/ State	Mental Health	General fund, Medicaid (including FFS/managed care/waivers), federal mental health block grant, redirected institutional funds, and funds allocated as a result of court decrees
	Child Welfare	Title IV-B (family preservation), Title IV-B (foster care services), Title IV-E (adoption assistance, training, administration), and technical assistance and in-kind staff resources
	Juvenile Justice	Federal formula grant funds to states for juvenile justice prevention, state juvenile justice appropriations, and juvenile courts.
	Education	Special education, general education, training, technical assistance, and in-kind staff resources
	Governor's Office/Cabinet	Special children's initiatives, often including interagency blended funding
	Social Services	Title XX funds and realigned welfare funds (TANF)
	Bureau of Children with Special Needs	Title V federal funds and state resources

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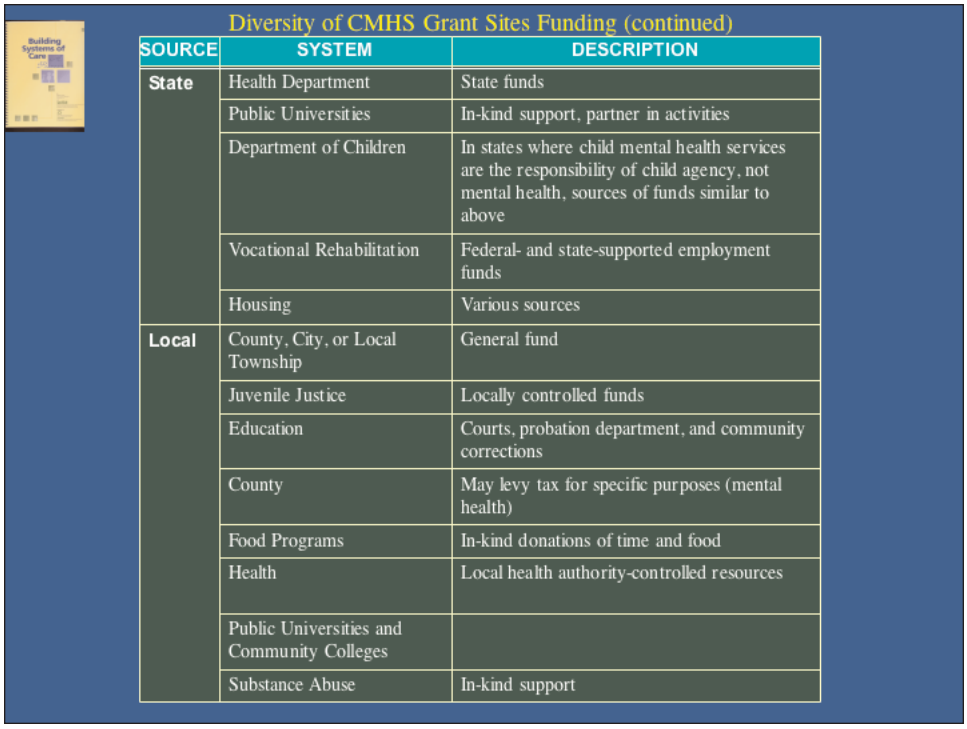

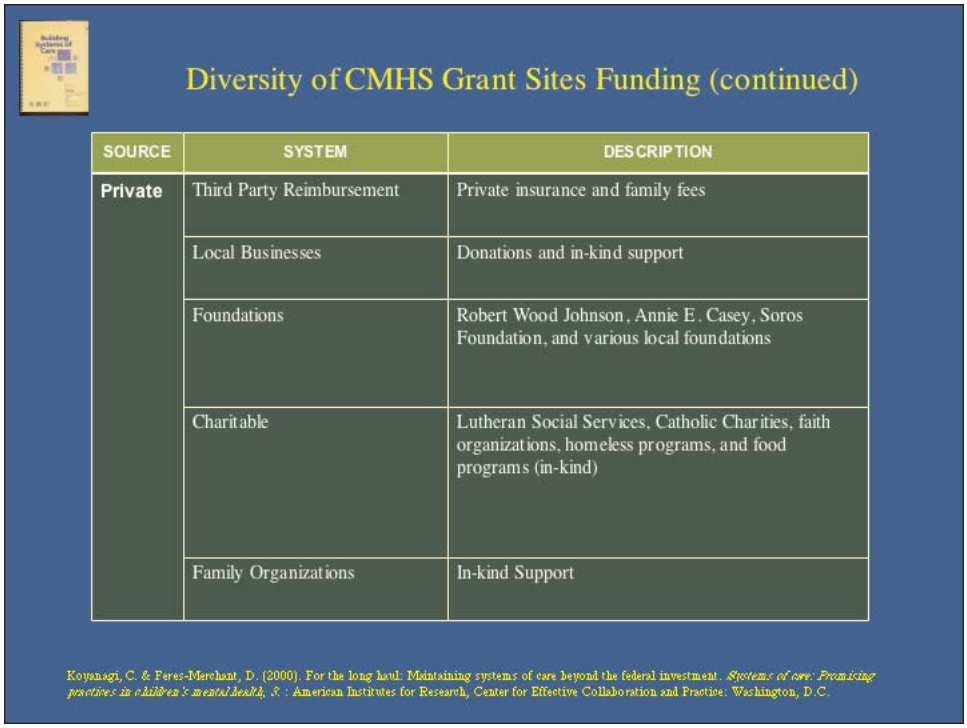

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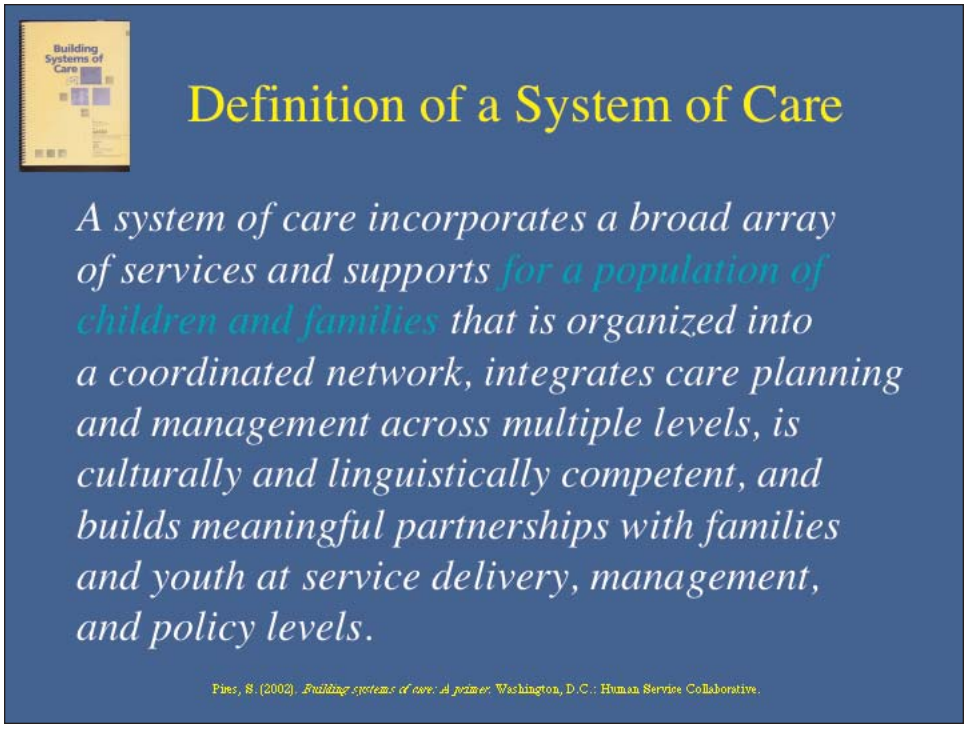

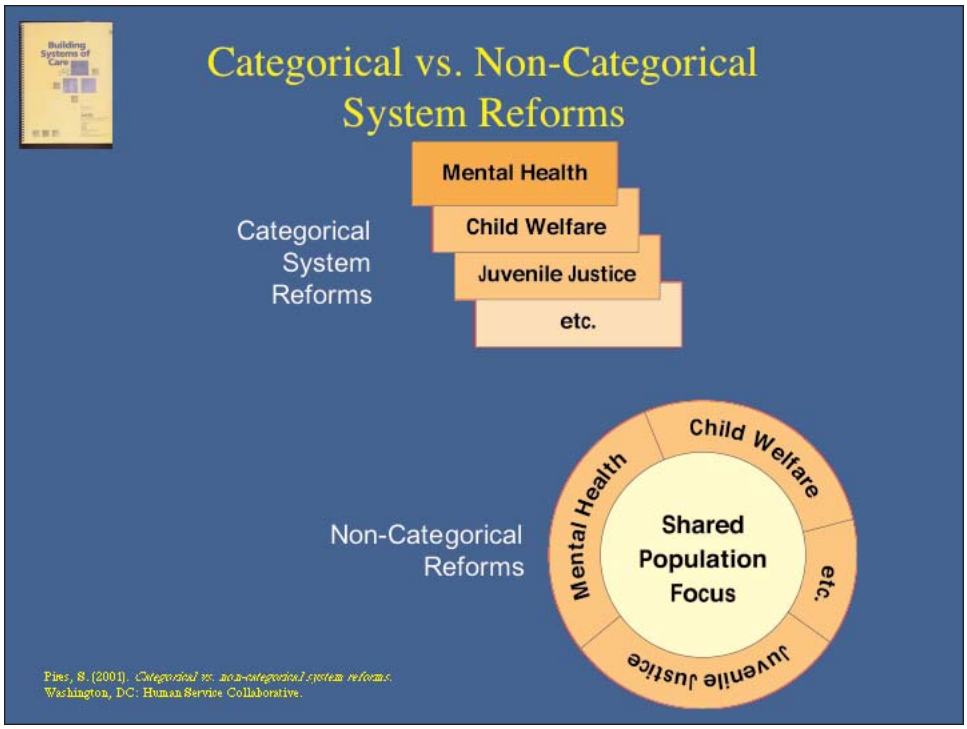

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New Generation of Managed Care

•Integrates payer, manager and provider ^ of care into an integrated delivery system *and family/consumer*

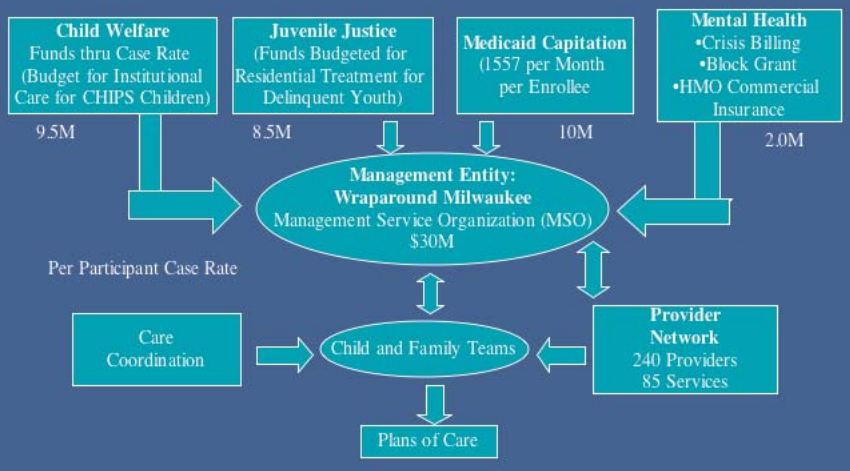
•Focuses on a delivery system that provides (treatment) ^ for a defined population of (patients) ^ in a defined geographic area *services and supports* *children and families*

•Provides continuity of care over a full continuum of care through the entire (episode of the patient's illness) ^ *period a child and family needs services*

•Has a results orientation that measures not only the process of care, but the satisfaction of (patients) ^ and the outcome of the ^ (treatment) provided *families/ consumers* *services and supports*

Adapted from MEDCO Behavioral Health Care Corporation, 1994

Wraparound Milwaukee



Wraparound Milwaukee. (2002). What are the pooled funds? Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch

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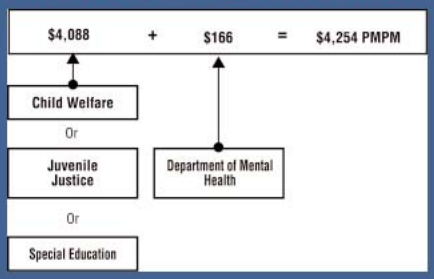
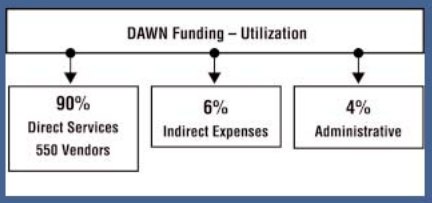
DAWN Project
Indianapolis, IN

How Dawn Project is Funded



Dawn Project Cost Allocation



Management Entity:
Non profit behavioral health organization

More Dawn Features

Life Domains
Health/medical
Safety/crisis
Family/relationships
Educational/vocational
Psychological/emotional
Substance abuse
Social/recreational
Daily living
Cultural/spiritual
Financial/legal

- Service coordination plans, including safety and crisis plan
- Broad array of treatment and supportive services
- Extensive provider network, paid fee for service

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Dawn Service Array

Behavioral Health
Behavior management
Crisis intervention
Day treatment
Evaluation
Family assessment
Family preservation
Family therapy
Group therapy
Individual therapy
Parenting/family skills training
Substance abuse therapy, individual and group
Special therapy

Psychiatric
Assessment
Medication follow-up/psychiatric review
Nursing services

Mentor
Community case management/case aide
Clinical mentor
Educational mentor
Life coach/independent living skills mentor
Parent and family mentor
Recreational/social mentor
Supported work environment
Tutor
Community supervision

Dawn Service Array, Continued

Placement
Acute hospitalization
Foster care
Therapeutic foster care
Group home care
Relative placement
Residential treatment
Shelter care
Crisis residential
Supported independent living

Respite
Crisis respite
Planned respite
Residential respite

Service Coordination
Case management
Service coordination
Intensive case management

Other
Camp
Team meeting
Consultation with other professionals
Guardian ad litem
Transportation
Interpretive services

Discretionary
Activities
Automobile repair
Childcare/supervision
Clothing
Educational expenses
Furnishings/appliances
Housing (rent, security deposits)
Medical
Monitoring equipment
Paid roommate
Supplies/groceries
Utilities
Incentive money

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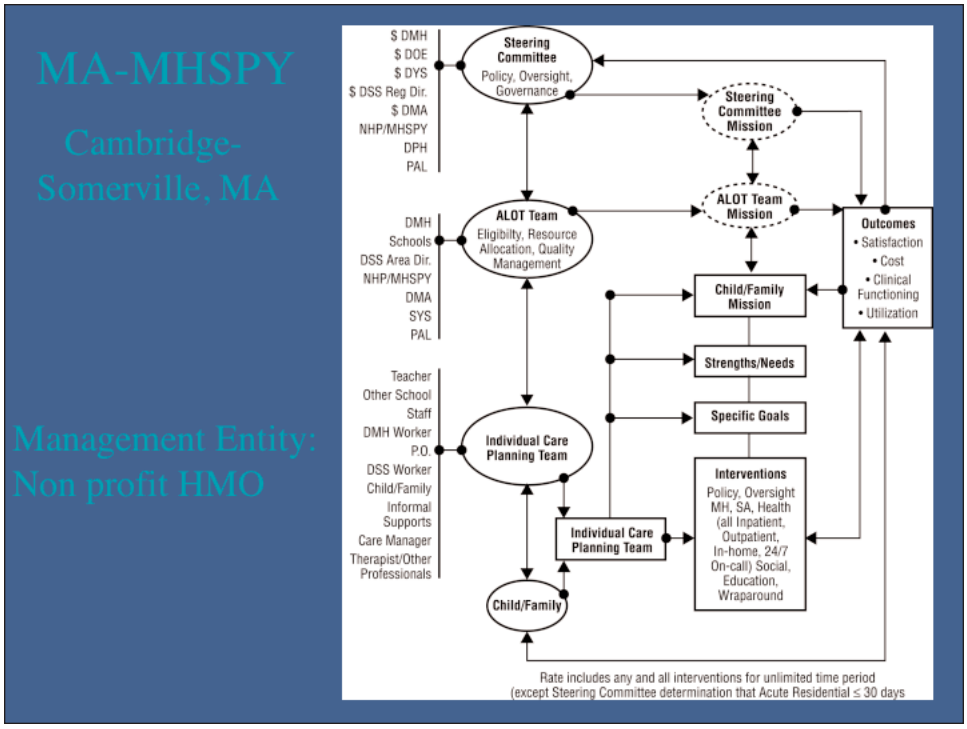

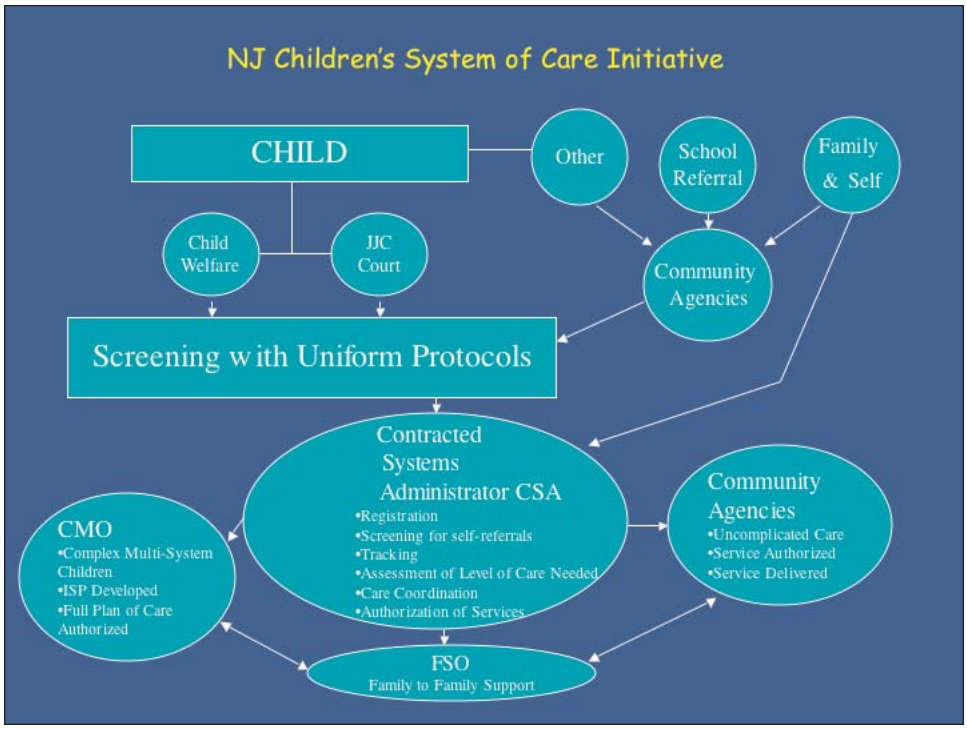

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OUTCOMES (Milwaukee Wraparound)

- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- Decrease in average daily RTC population from 375 to 50
- Reduction in psychiatric inpatient days from 5,000 days to less than 200 days per year
- Average monthly cost of $4,200 (compared to $7,200 for RTC, $6,000 for juvenile detention, $18,000 for psychiatric hospitalization

OUTCOMES (MA-MHSPY AND OTHER MA-WRAPAROUND)

- Reduction in use of prescription meds
- Reduction in overall cost
- Improved functioning at home, school, and in the community
- Parents feeling more confident and capable in managing their children's challenging behaviors
- Reduced utilization of out-of-home care

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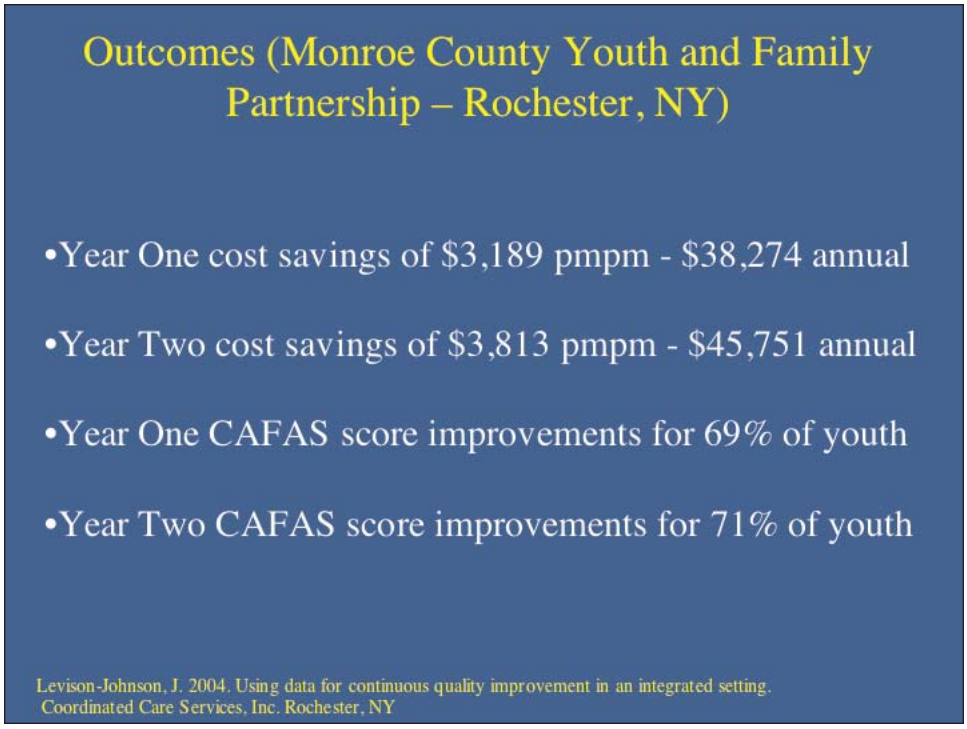

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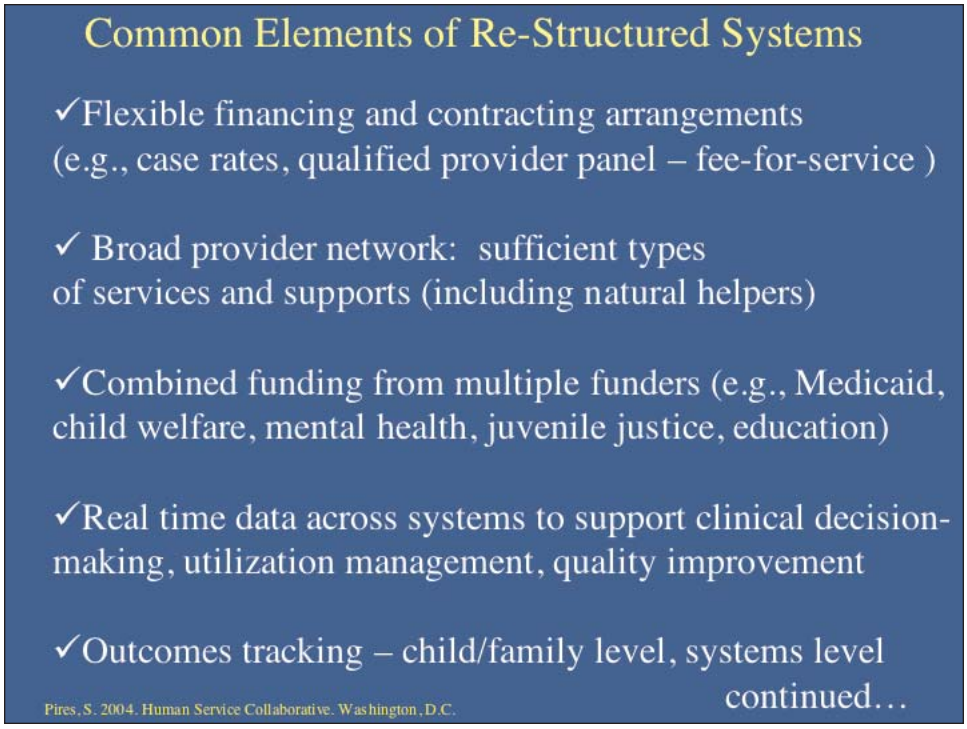

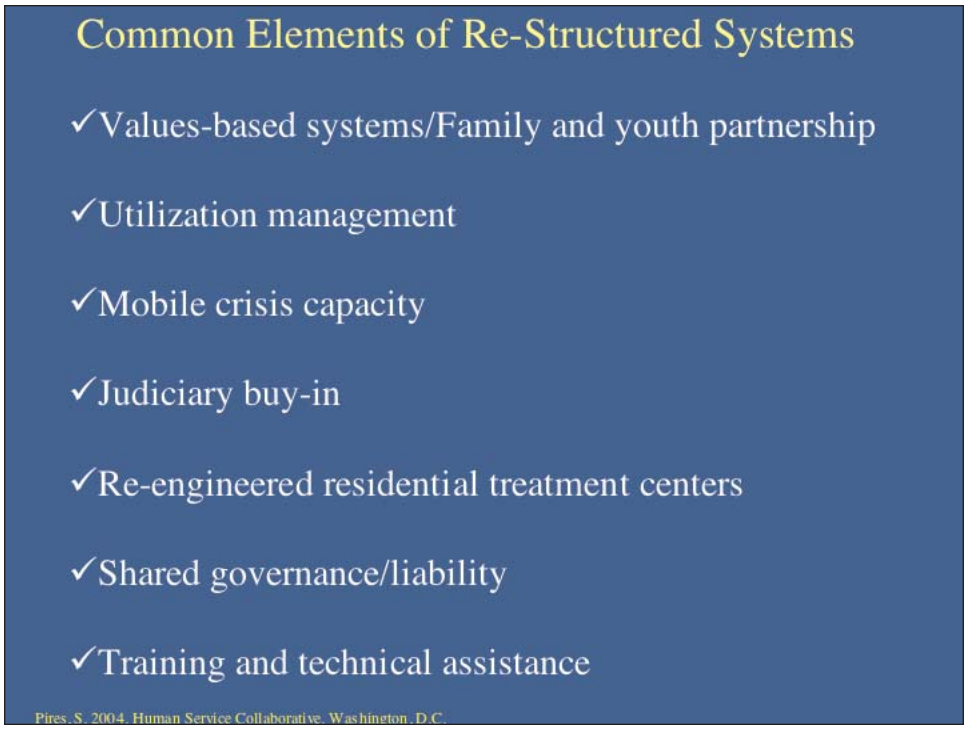

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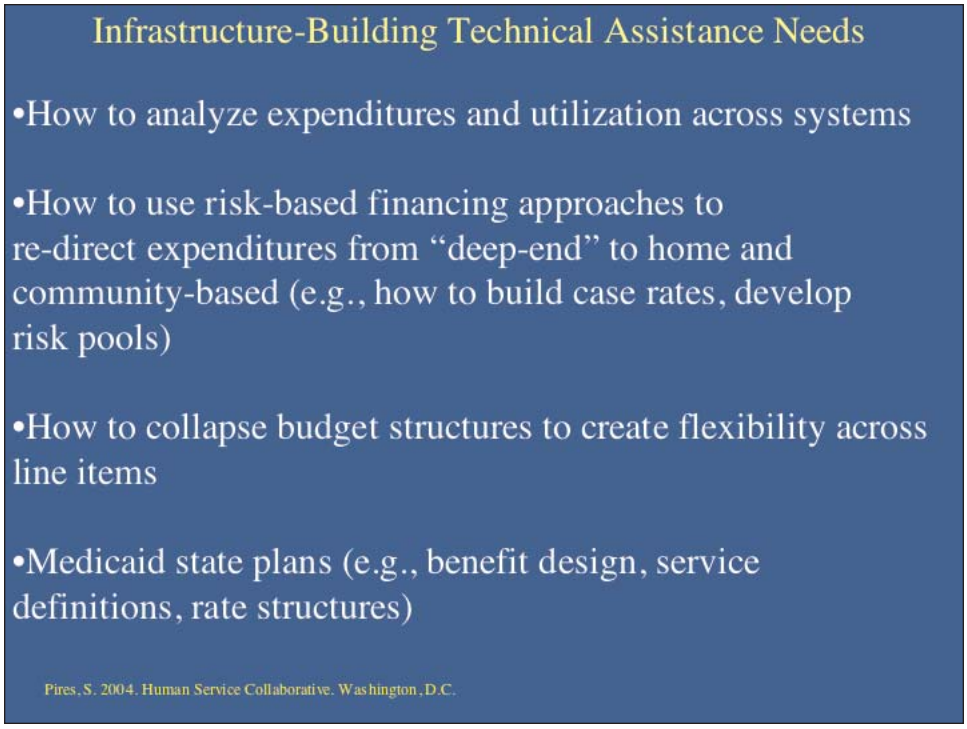

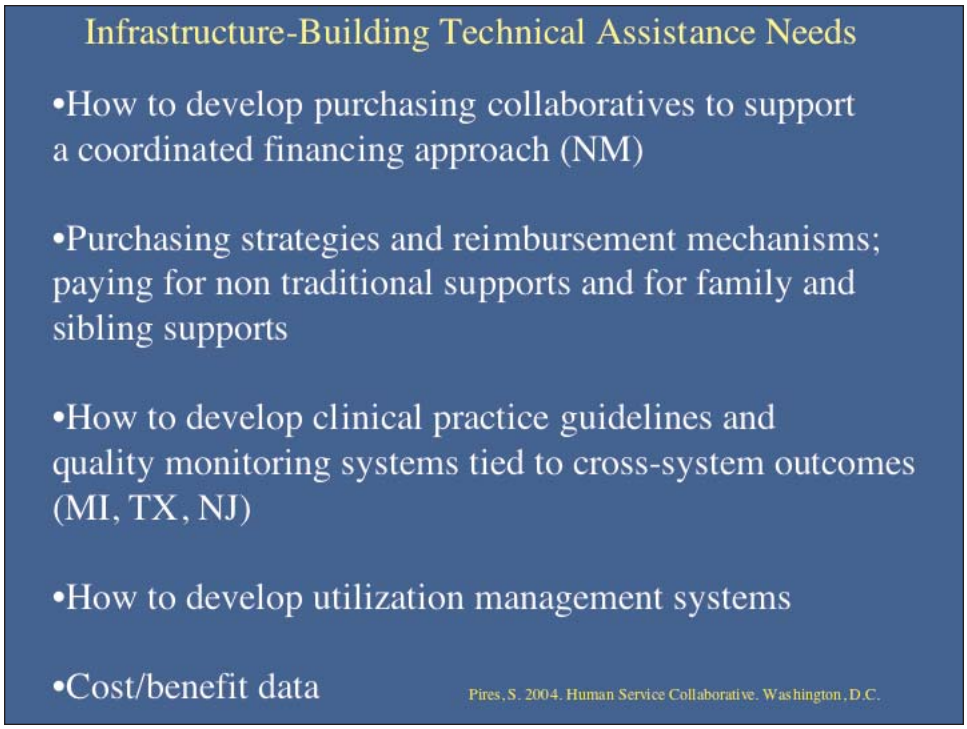

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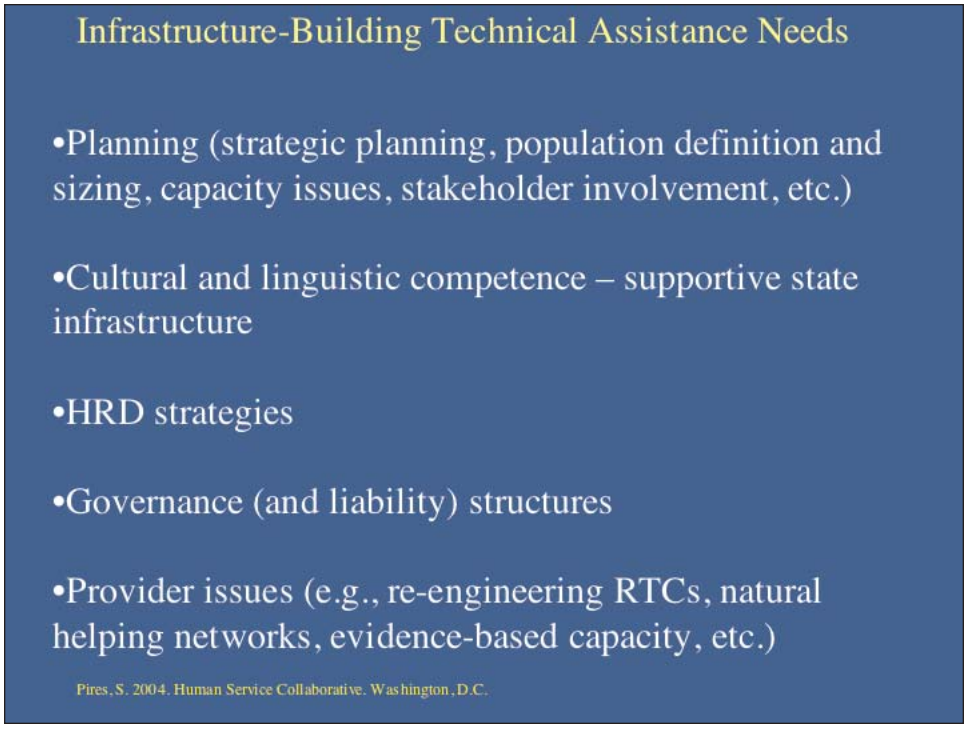

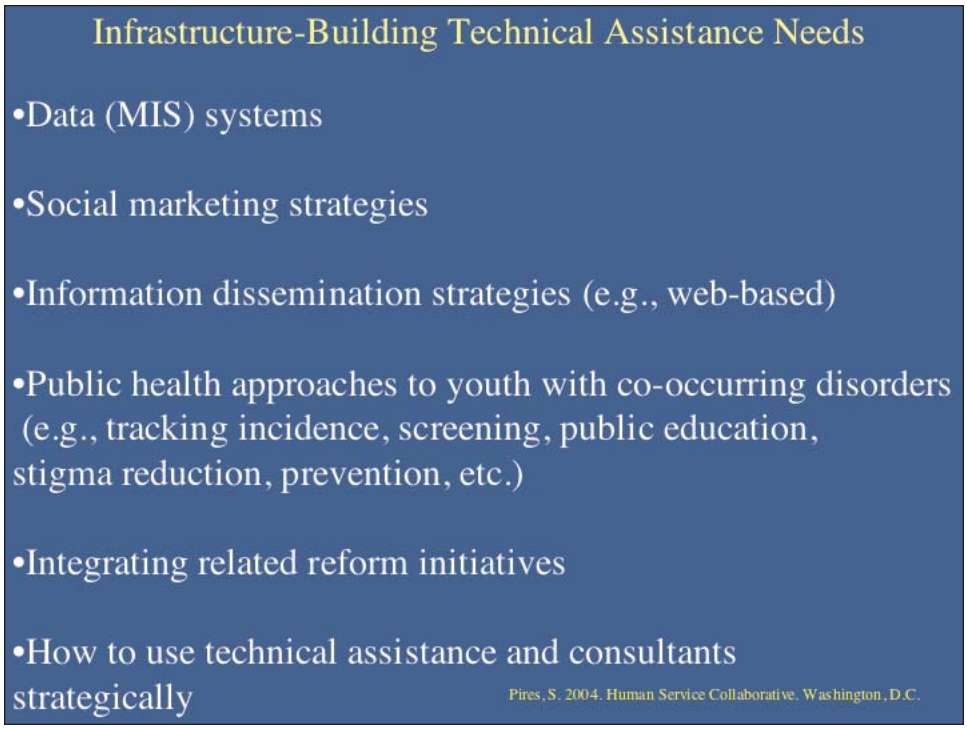

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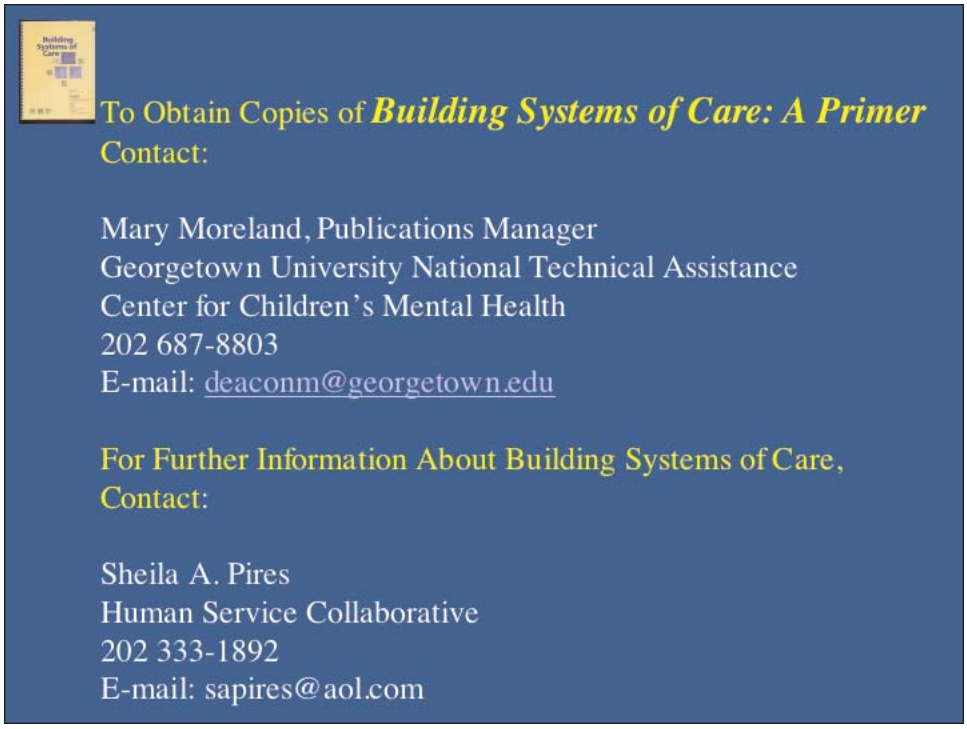

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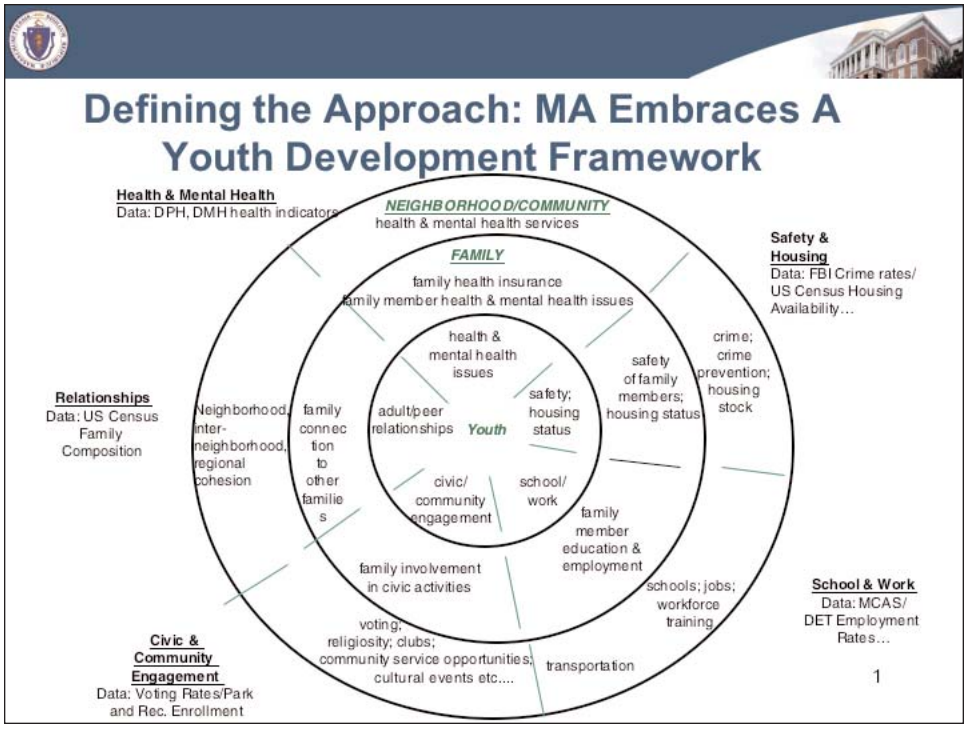

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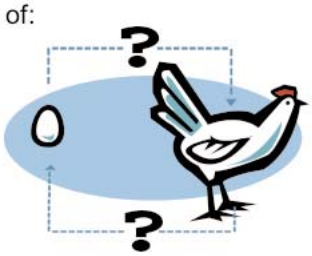
Defining the Population:

- A classic problem of:



- Which Trumps Which DD or SED?
- Relevant for eligibility and treatment decisions. Particularly important when youth "ages out" of child system into adult services.

2

Defining Medicaid Covered Services

- New services developed- no guidance from CMS
- If one state covers a service using Medicaid dollars, does that mean it is a covered service? Medical Necessity Criteria Rules.
- Federal Waivers/ cost neutrality factor

3

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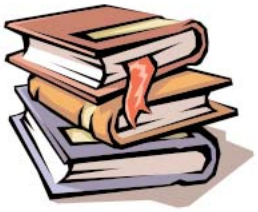
Defining Terms: Rehabilitation versus Habilitation & Early Intervention as a Hybrid

Habilitation- The cause of the condition



Rehabilitation- treatment to optimum functioning- covered by Medicaid

Early Intervention- Rehabilitation services covered by Medicaid

4

Defining Appropriate Care: Treating Youth with SED and DD is a Specialty

Youth Hospitalized

- ❖Specialty Units
- ❖1:1 Specialing

Differential Diagnosis

- ❖Limited ability to describe problems

5

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Defining Trained Staff: NCQA

- Utilizing Services across systems-credentialing barriers
- Training Programs specific to this population

- Incentives to providers to develop specialty services

6

Defining Responsibility: When Does The School Day End?

- After school services identified by families as most needed service
- Respite
- Children awaiting a disposition regarding a cost share

7

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Defining Payment Options: Case Rates

- Flexibility with Case Rate
- Outcomes Driven
- Need to itemize services
- Lack of Direction

8

Defining The Way We Do Business: Examples of Best Practices

Care Coordination/Targeted Case Management
- Covered but under great federal scrutiny

Individualized Flexible Plan (and only one!)
- Team meetings/ administrative expense
- Data systems for sharing the IFP

Involve Families in Planning
- Pay for time/daycare etc.

9

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Defining Expectations: Collaboration

Planning Review Teams

- Best efforts at collaboration _
- Family Participation in the design _
- Attempt to be responsive to families bumping multiple systems utilizing Systems of Care Principles _
- Major drawback- no new $$$

DOE/DMR Partnership

- Family supports to avoid residential placement

10

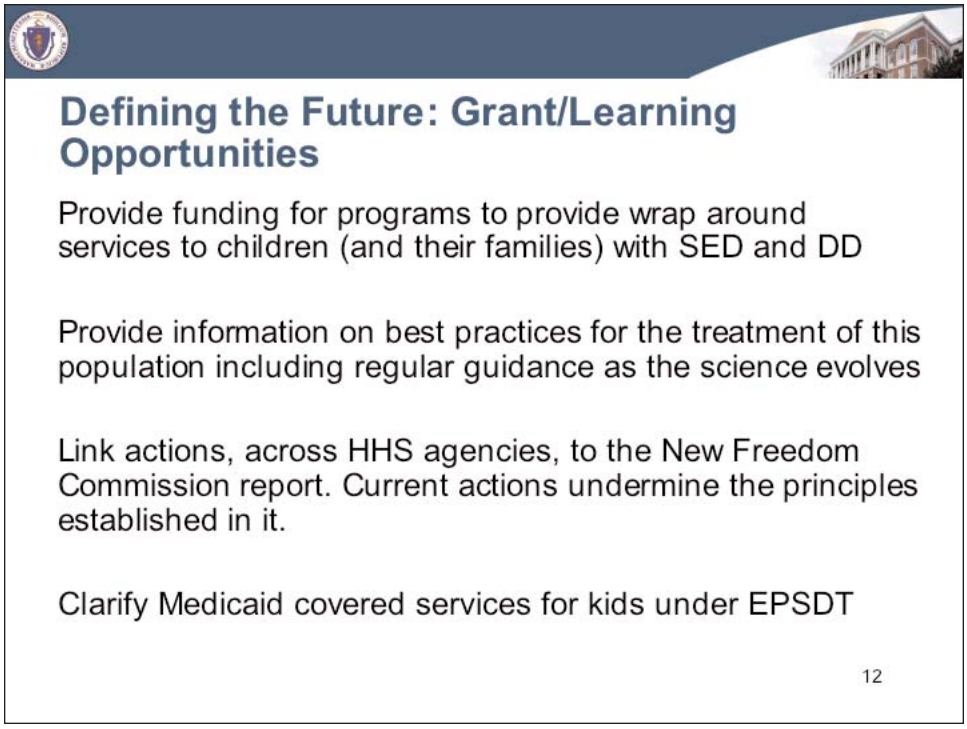
Blended Funding System of Care Model:

- Youth with Co-Occurring Disorders Enrolled in Systems of Care Pilots

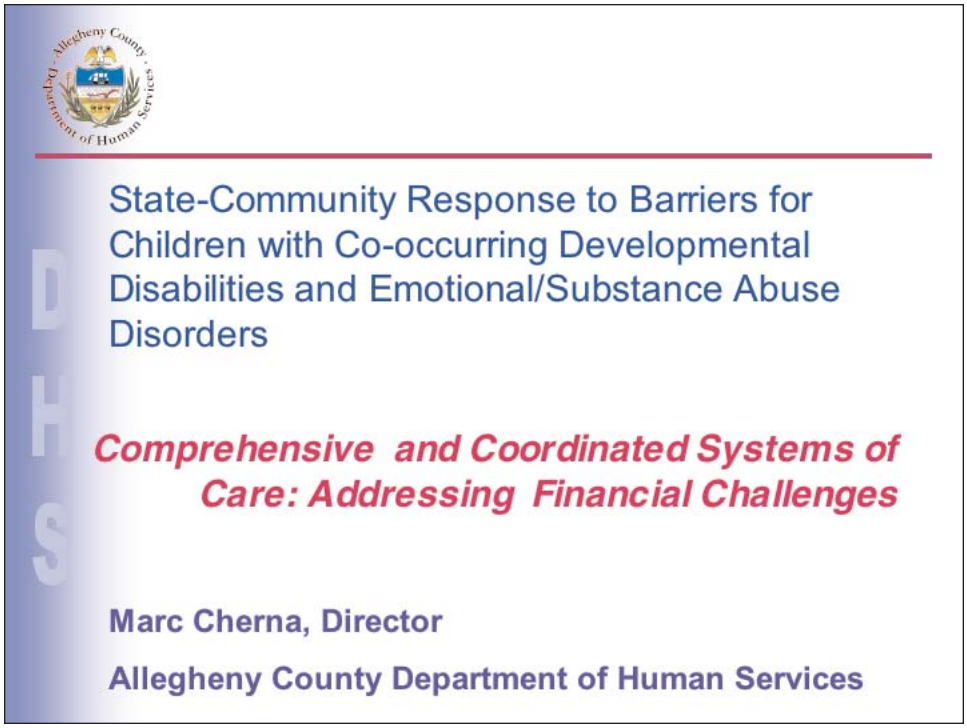
Case Example:

11

KATHLEEN D. BETTS, M.P.H.



MARC CHERNA, M.S.W.
Director, Allegheny County Department of Human Services
Pittsburgh, Pennsylvania



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Allegheny County Statistics

- 28th largest county in the nation
- 1.3 million residents
- 130 municipalities
- 91 neighborhoods in the City of Pittsburgh

Allegheny County Statistics

Persons Served Annually - Approx. 250,000

Total Staff – approximately 1,100

Service Providers - Approximately 400

- 820 contracts for over 1,800 discrete services

Total Budget - $757.4 million

- (55% federal, 42% state, 3% county)

Funding Sources - 80

- each with separate laws, regulations, and reporting requirements

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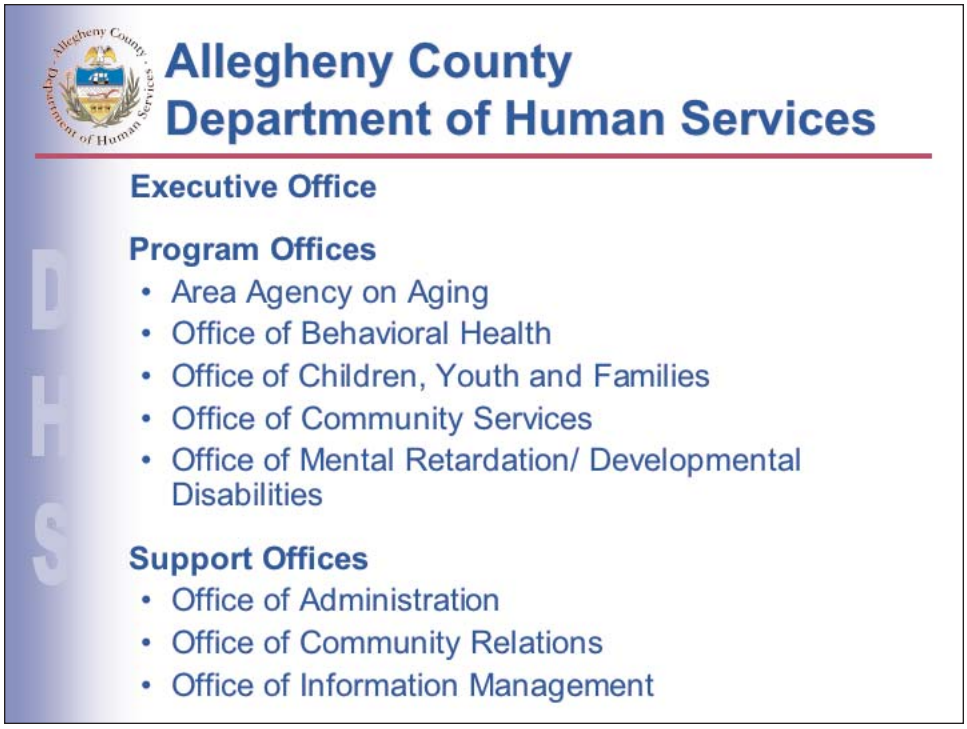

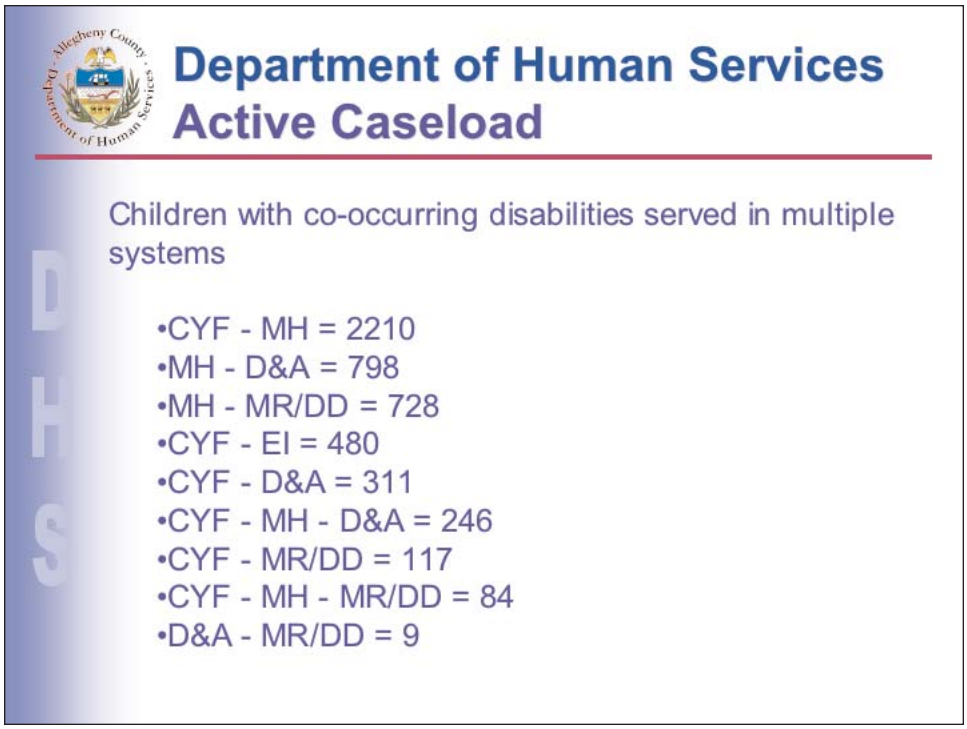

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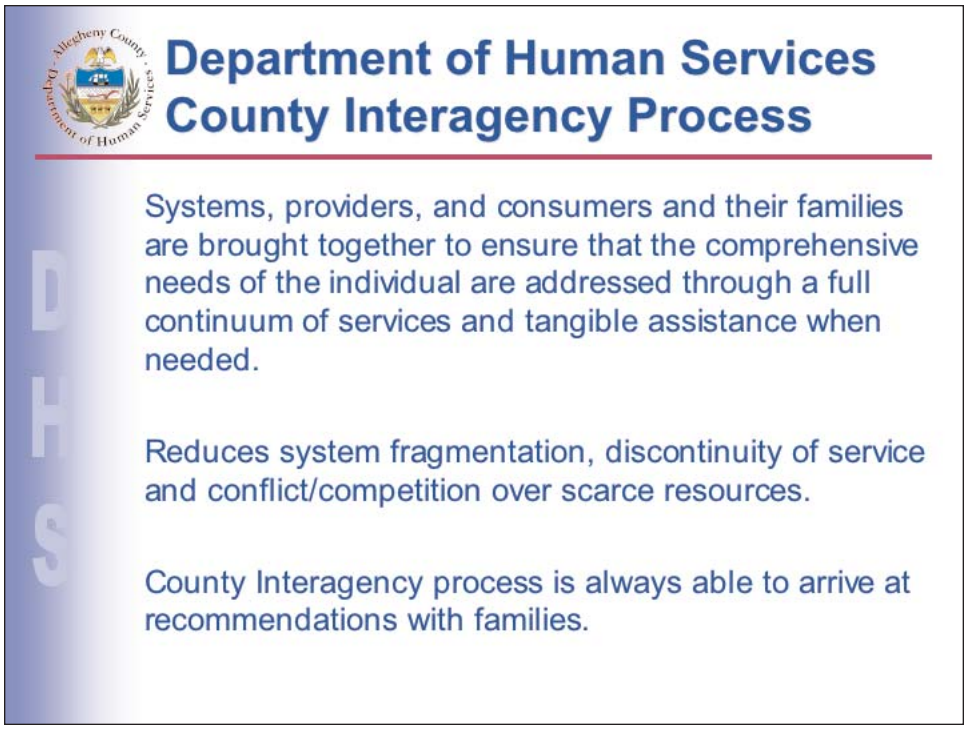

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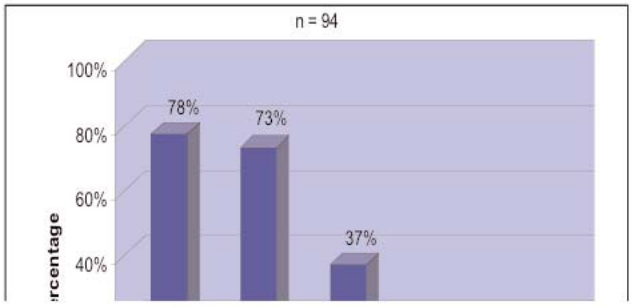
Department of Human Services County Interagency Process

During FY '03/04:

- 109 Interagency meetings were held for 94 individual children/adolescents.
- Of the 109 Interagency meetings, only 10 required referrals to the multi-system team for additional planning.

Department of Human Services County Interagency

Multi-system Involvement



85% of those children /adolescents referred for County Interagency Review have multi-system involvement.

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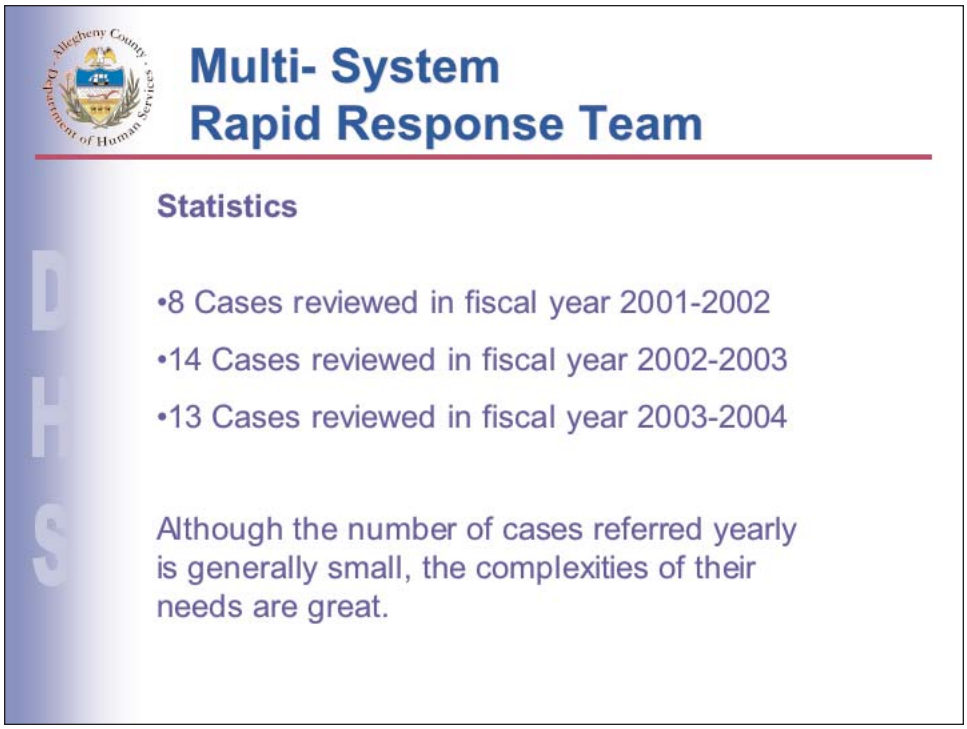

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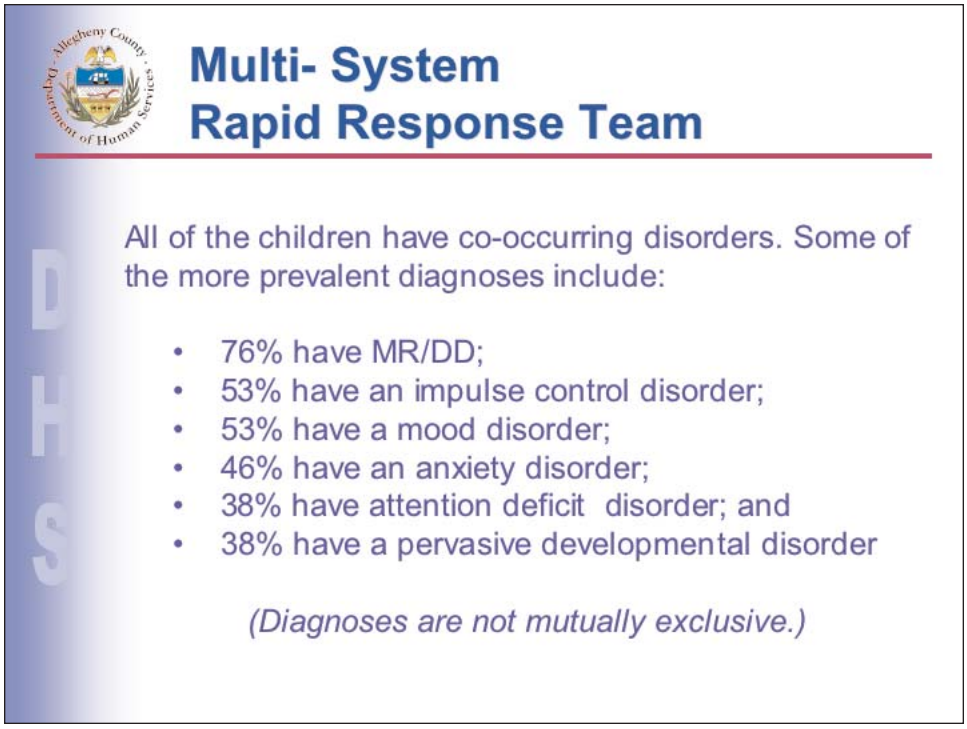

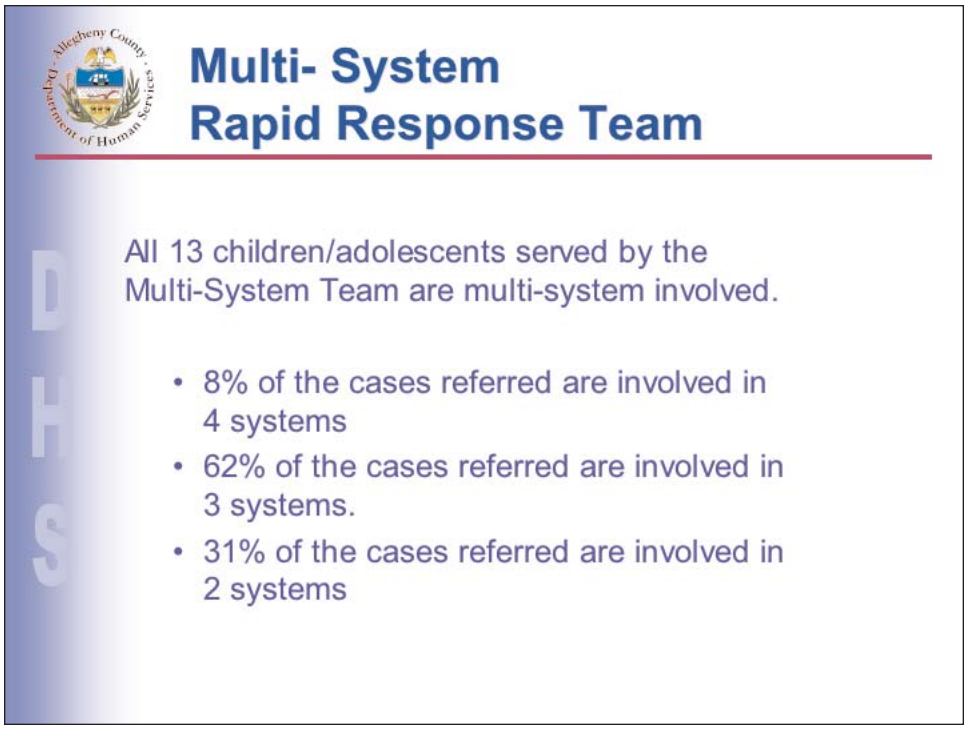

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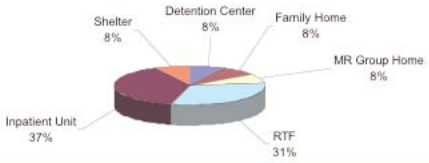
Multi- System Rapid Response Team

The greatest number of children at the time of referral were inpatient with no viable discharge options.

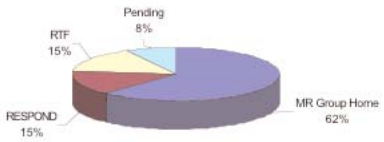
Consumer Placement At Referral

FY 03-04



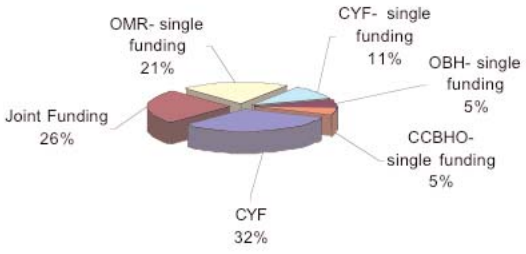
"Packages" of tailored support services and resources from multiple systems were put together to allow the child to return to a community setting, resulting in the majority (62%) of individuals going to MR group homes.

Disposition Setting
FY 03-04



Multi- System Rapid Response Team

Funding Distribution



Funding is determined after the needs are identified. It typically is not on the table for discussion during the planning process.

Shared funding from all three program offices occurs frequently based on eligibility.

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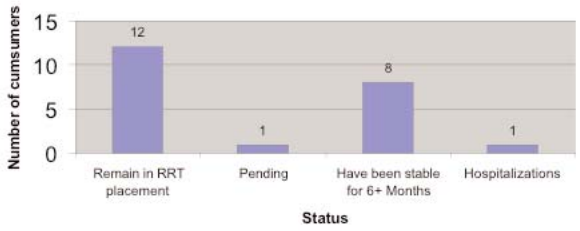
Multi- System Rapid Response Team

Sustainability FY 03-04



92% of cases that were referred have secured a viable placement (1 pending)

92% of RRT placements have been sustained. One individual, who had maintained placement for 8 months, experienced a brief hospitalization.

Department of Human Services New Resources

RESPOND

- 10 admissions to the program
- 5 Successful discharges to community settings- with no hospital admissions post-discharge.
- Only one individual of 10 experienced a 24-hour hospitalization as a resident of RESPOND
- 5 Individuals who had failed or plateaued in RTF level of care demonstrated progress/success in this unique level of care
- Medications have been reduced for each individual
- Better coping skills have been obtained as evidenced by the reduction in aggressive behaviors for each resident
- Successful discharge planning for all residents
- Better systems collaboration and communication

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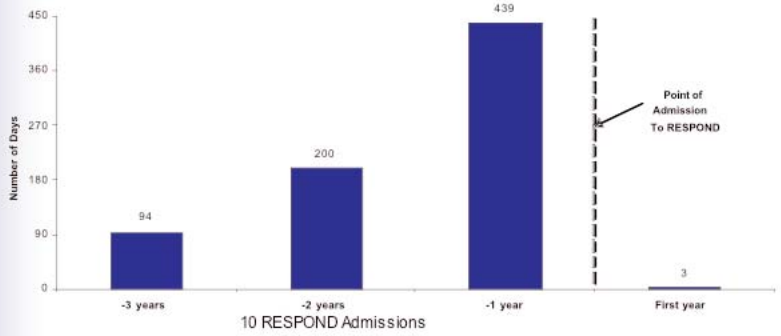
Department of Human Services New Resources



Department of Human Services Integrated Children's Plan

New requirement of Pennsylvania Department of Public Welfare in 2004

- Brings together key stakeholders in child welfare, drug & alcohol, mental health and mental retardation systems

Focus on launching and expanding cross-systems initiatives that don't fit neatly into existing silos

- Examples: Building common information systems, providing coordinated case management services, serving children with physical disabilities

Process currently includes child welfare budget only

- Possibility of folding in mental health and mental retardation budgets for children in the future

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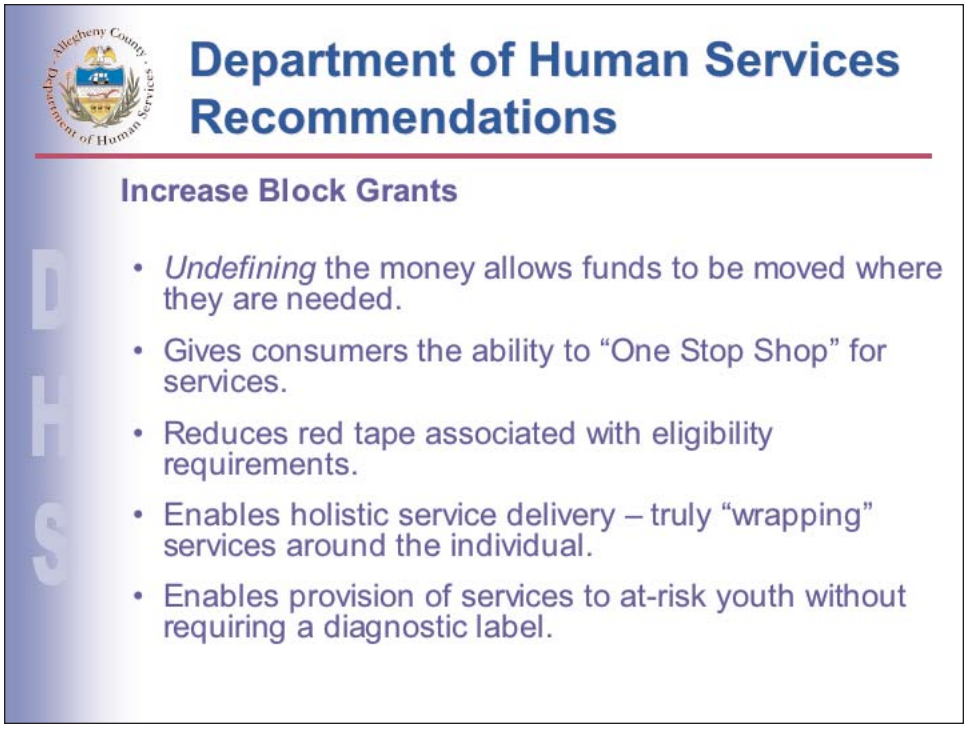

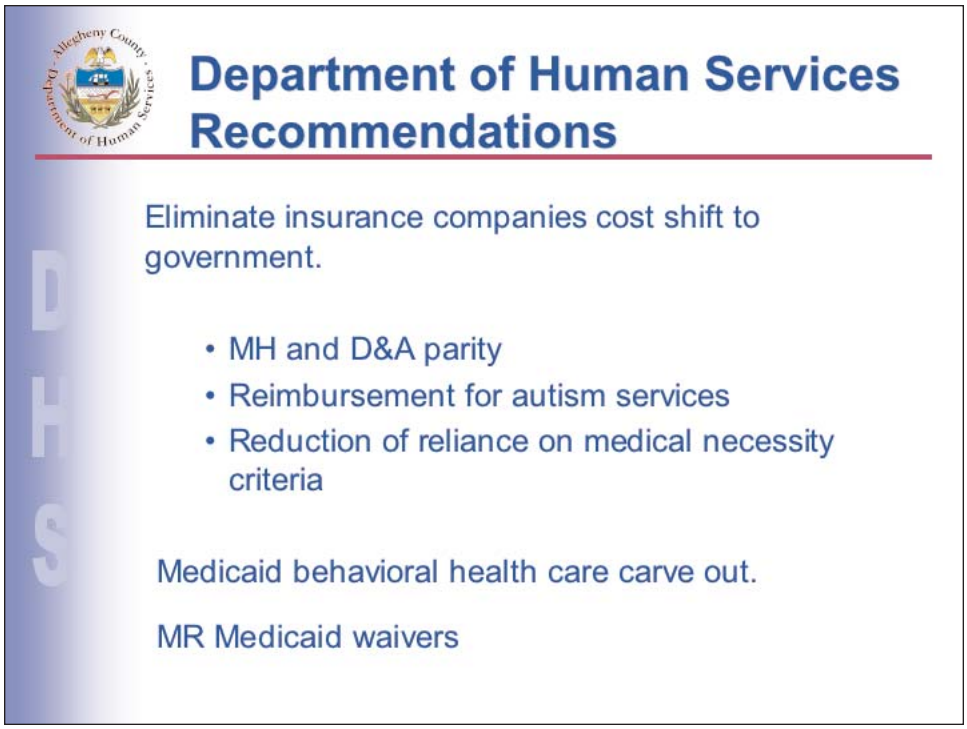

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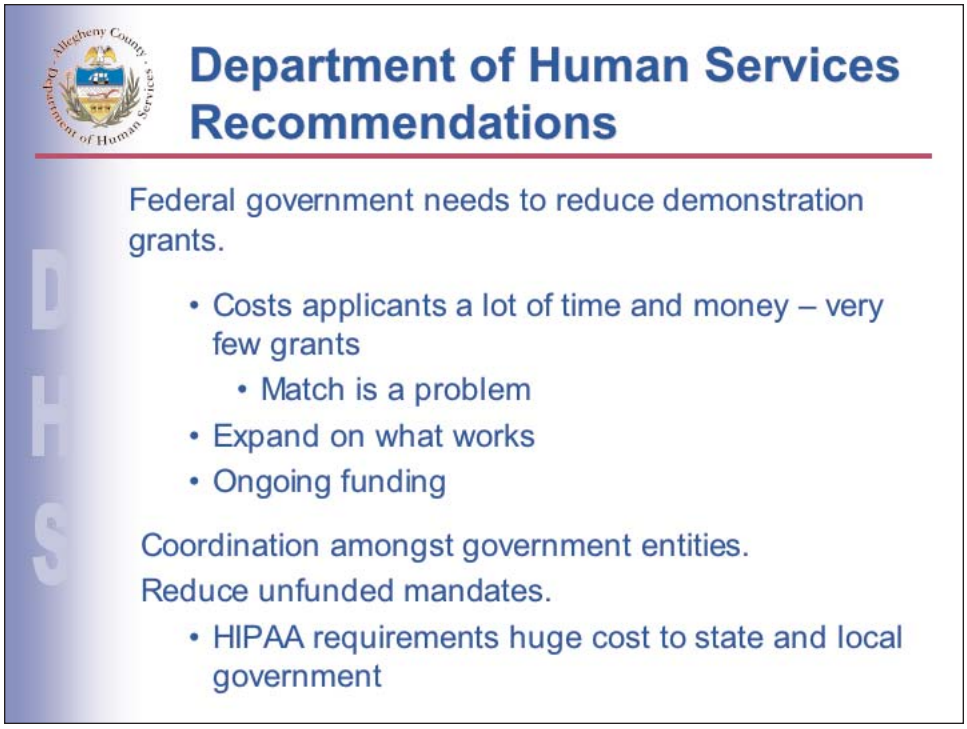

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