COURT IMPROVEMENT PROGRAM TRAINING

Services in the Child Welfare System

A Multi-disciplinary Curriculum for Improvement of the Child Welfare System

Services in Child Welfare System:

A Multi-Disciplinary Curriculum for Improvement of the Child Welfare System

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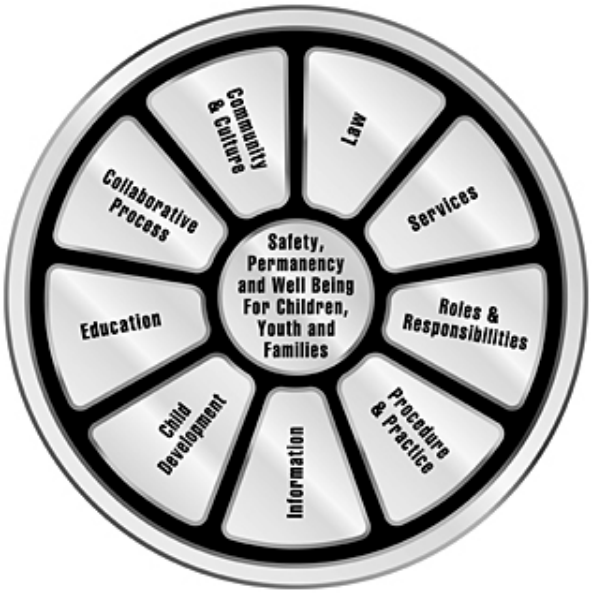

Colorado Court Improvement Program Training Wheel Curricula

It is not surprising that the diverse culture of the child welfare system creates knowledge and experience gaps for child welfare participants and practitioners alike, which leads to the question, "How can individuals who are involved in the child welfare system know about that system as a whole as well as the roles of others involved in it?"

The Colorado Court Improvement Program (CIP) is in the process of designing training to answer this very question. The Training Wheel Curricula is made up of nine separate modules, each representing a discipline or service area associated with the Child Welfare process. The purpose of each module is to assist multi-disciplinary Best Practice Court Teams in building a foundation of core knowledge within each discipline or service area. While each discipline or service area may have a required professional knowledge and skill base that exceeds core knowledge, it is core knowledge in all areas that creates an understanding of the child welfare process as a whole.

The *Services in the Child Welfare System* curriculum was authored by Dr. Skip Barber, the Director of the Colorado Association of Family and Children's Agencies, 1120 Lincoln St., Suite 701, Denver, CO 80203, (720) 570-8402, email address skipbarber@earthlink.net.

For questions about the *Services in the Child Welfare System* curriculum or about other Training Wheel curriculum, please contact Kay Yorty, Training Coordinator for the Colorado Court Improvement Program at margaret.yorty@judicial.state.co.us

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SERVICES IN THE CHILD WELFARE SYSTEM

Time: 7 hours

Purpose: Stakeholders will have an understanding of the service needs for families; the service providers that are available and accessible in their jurisdictions; and will be empowered and enabled to use their community partners in developing and delivering necessary services so that children and youth will be provided with safety, permanency and well-being.

Competencies/
Learning Objectives

Following the training, participants will have an understanding of the following issues and/or demonstrate the following qualities regarding the collaborative process:

- The type of services that can be sued to assist children and families
- What services are required by law or regulation
- The assessment process to determine need and eligibility (funding) for certain services
- The availability of services within the community
- The need for services with the community
- Types and availability of community support partners (Indirect services: food banks, public transportation, etc.)
- Best practices for the provision of services

Training Objectives

- Stakeholders will demonstrate a working knowledge of the services each community is required to provide pursuant to C.R.S. §19-3-208 and a working knowledge of how to effectively advocate if such services are inaccessible.
- Stakeholders will demonstrate a working knowledge of the case planning methods mandated by Volume 7.
- Stakeholders will demonstrate a working knowledge of the services that may not be required by statute but which are available and accessible within their region that may be necessary to meet the reasonable efforts requirement.

- Stakeholders will demonstrate a working knowledge of how the reasonable efforts requirement can be used to develop appropriate services that do not yet exist.
- Stakeholders will demonstrate a working knowledge of services that are available in best practice communities and how to develop programs and resources to make them available in their own communities.
- Stakeholders will demonstrate a working knowledge of the streams of funding and their limitations.
- Stakeholders will demonstrate a working knowledge of strategies to overcome challenges caused by lack of transportation, limited capacity of programs, disability of client, lack of services in the client's first language, providing services to undocumented residents, overcoming barriers presented by gender, cultural or racial bias, for example.

Materials

All materials as well as this curriculum are provided in electronic and printed format.

Faculty Resource 1:	Background research and references
Faculty Resource 2:	Services PowerPoint Presentation
Handout 1:	Agenda
Handout 2:	Evaluation
Appendix A:	Services Across Funding Sources
Appendix B:	Core Services Utilization by Counties
Appendix C:	Waiver Programs for Colorado Children
Appendix D:	Listing of BHOs
Appendix E:	References/Bibliography

Expectations of Faculty

The trainer must be knowledgeable about the service delivery system in Colorado. Ideally, the trainer should have a background in the provision of clinical services. The trainer must thoroughly familiarize him/herself with this curriculum. All trainers must also be skilled in facilitating productive discussion amongst diverse groups of stakeholders.

Facilitators of the small groups may come from any of the professions represented in the child welfare and court system. The ideal facilitator is someone who will ask probing questions, facilitate a civil discussion, redirect participants who may dominate the discussion, and keep the group on task.

SERVICES TRAINING PREPARATION

Facility: The ideal facility is a meeting room large enough to accommodate the number of registrants. Participants should be seated in groups that are diverse in terms of stakeholder role. Ideally, the room will be set up with rounds to seat up to 8 participants. If rounds are not available, space and seating should be flexible in order to accommodate face-to-face interaction of small groups. The main meeting room should have audio equipment so that all participants can easily hear the presentations. It must have a screen or a wall that is appropriate to display a PowerPoint presentation.

Recruitment: A diverse group of stakeholders is essential to the success of this training. For this reason slots should be reserved for stakeholders representing various groups, including: judicial officers, court staff, family court facilitators, guardians ad litem, respondent parent counsel, county attorneys, CASAs, DHS caseworkers, supervisors and managers, foster youth, parents and grandparents, educators, foster parents, visitation supervisors/therapists, mediators, psychologists, mental health and drug and alcohol treatment providers, tribal representatives, etc. It will be essential to assure attendance of and involve lead judges in the recruitment of other participants. In order to do this it is important that the training be scheduled far enough in advance to allow participation by judicial officers whose dockets are scheduled at least 6 months in advance.

After registration has closed, the Lead Faculty should divide the class into discussion groups that are diverse in terms of stakeholder roles. Colored dots or numbers should be used on the nametags to delineate the groups.

If advance registration does not reflect sufficient diversity of stakeholders, the Lead trainer must take steps to assure recruitment of an appropriate blend.

Lead Faculty must assure that registration forms include email addresses for all participants as materials and notices will be sent to participants via their email addresses both before and after the training. The person delegated to be in charge of registration should create a distribution list to be used for registrant communication.

Lead Faculty should monitor early registration and where necessary contact Lead Judges so that a diverse group of participants can be assured.

WELCOME AND INTRODUCTIONS
Allocated Time: 15 minutes

💻 Slides 1-2: Welcome and Introductions

- Welcome
- Introductions
- Review of Logistics
- Review of Schedule

Welcome participants to Services Training and thank them for taking the time out of their busy schedules to improve their system. Thank them for participating.

Briefly introduce yourself (your biography for introduction should be included in the materials), explain your background in the service sector of child welfare and take a moment to explain why you are committed to education as a means of helping to improve the lives of children and their families.

Thank the organizers of the training and the rest of the faculty.

Explain that although many of the participants may already know several people, not everyone does, and it is important to wear their nametag. Ask participants to participate in an introduction activity. Dependent on the size of the group either have the full audience introduce themselves of instruct the participants to do introductions at their table. In their introductions they should give their name, their stakeholder role (agency and position), how long they have been in their current role, and the single greatest strength in the child welfare court and agency system in assisting families and children, and why they consider that to be a strength. Explain that each introduction should be less than a minute.

Take care of housekeeping issues including:

- *Information about the facility (restrooms, parking, breakout rooms)*
- *Participant materials*
  - *Expense reimbursement forms and rules*
  - *CLE forms*

Review Agenda for the day.

ACTIVITY: EFFECTIVE SERVICES AND UNADDRESSED NEEDS
Allocated Time: 15 minutes

Prior to the training, divide the participants into table groups so that people from different jurisdictions and different professional roles are seated together. As an icebreaker, give the participants at each table 10 minutes to share their responses to the questions on Slide 3. Then for the remaining 5 minutes have each table report to the large group three services that they have seen work effectively and three barriers that exist. Record these answers on a flip chart.

💻 Slide 3: **Group Activity**

- Identify the services that you have seen work most effectively with youth
  - What were the needs of the children served that this program addressed?
  - What are the key elements that you think contributed to these services being successful?
- In your experience what youth needs have not been addressed successfully? What barriers, if any, contributed to the lack of these needs being met?
  - Lack of resources?
  - Lack of accessibility?
  - Lack of expertise?
  - Poor quality of services?

SERVICES INTRODUCTION

Allocated Time: 30 minutes

💻 Slide 4: Goals for Services Training

- Increase participant knowledge of services available in Colorado.
- Increase participant awareness of the variety of services and the funding streams supporting them.
- Explore means to ensure that each child receives "the right services at the right time" (DYC's mission statement but a good objective for us all).

Begin the training by discussing the goals for the day and the importance of gaining increased knowledge in this area of the child welfare system.

💻 Slides 5: Services Mandate within Child Welfare

- **C.R.S. §19-3-208**. Services - county required to provide - rules. (1) Each county or city and county shall provide a set of services, as defined in subsection (2) of this section, **to children who are in out-of-home placement or meet the social services out-of-home placement criteria and to their families in the state of Colorado eligible for such services as determined necessary by an assessment and a case plan**... Each county or city and county shall have a process in place whereby services can readily be accessed by children and families determined to be in need of such services described in subsection (2) of this section.

Discuss the services mandate enumerated in the statute. The trainer should be knowledgeable about the child welfare system and be able to provide information explaining each type of services on Slides 6-10, briefly discussing some of the differences between small and large counties in terms of operations and availability.

💻 Slides 6: Required Services

- (I) Screening, assessments, and individual case plans;
- (II) Home-based family and crisis counseling;
- (III) Information and referral services to available public and private assistance resources;
- (IV) Visitation services for parents with children in out-of-home placement; and

- (V) Placement services including foster care and emergency shelter

💻 Slide 7: Optional Services within Child Welfare if funding is available:

- Transportation
- Child care
- In-home supportive homemaker services;
- Diagnostic, mental health, and health care services;
- Drug and alcohol treatment services;
- After care services to prevent a return to out-of-home placement;
- Family support services
- Financial services
- Family preservation services

💻 Slide 8: Goals for Service

- Promote the immediate health, safety, and well-being of children
- Reduce the risk of future maltreatment
- Avoid the unnecessary placement of children into foster care
- Facilitate, if appropriate, the speedy reunification of parents
- Promote the best interests of the child

Discuss with the large group why these goals for services are important. Do we sometimes lose sight of these goals and allow other issues to influence the services that are provided to families in the child welfare system?

💻 Slide 9: Types of Services

- Service continuum arranged least to most restrictive/intrusive – generally services voluntarily solicited are less restrictive than mandated services
- Community Based Services
  - Family or individual support services
  - School based services
  - Alternative Schools and Day treatment
  - In-home services
  - Outpatient services

The notion of restrictiveness relates to the amount of disruption that the level of services creates for the family receiving the intervention. Therefore, services delivered in the family's home tend to be the least restrictive, and fewer services in general, tend to be less restrictive than more services. The level of services is generally dependent on the level of need that the client has and/or the level of risk (either that the child creates for the family or community or the risk of the child being further abused or neglected by the family). The goal is to match the level of services to the needs of the current situation and to require the most appropriate level of services required to successfully meet the demands of the current situation.

Slide 10: Services Continuum Continued

- Out-of-Home Services
  - Kinship Care
  - Foster Care
  - Group Care
  - Residential Treatment
    - *RCCF - Residential Child Care Facilities*
    - *TRCCFs – Residential Child Care Facilities (with the major distinction being staff awake 24/7 and the level of mental health treatment services)*
    - *PRTF – Psychiatric Residential Treatment Facilities (with the primary distinction being the mental health difficulties of the clients and the resulting amount of mental health treatment services)*
- Secure Out-of-Home Care
  - Secure residential *(many of these facilities are also TRCCFs)*
  - Detention
  - Psychiatric Hospitalization
  - State-run secure facilities

THE NEED FOR SERVICES – BIOLOGY AND ENVIRONMENT

Allocated Time: 30 minutes

💻 Slides 11-12: A Model of Human Development

- Individual development is a function of
  - Biology (Nature)
  - Learning from and interacting with our environment (Nurture)
  - Making choices (Free Will)

Nature, referring to heredity; nurture, referring to the environment; and choice, referring to self-determination are three very reasonable explanations to why we are the people we are today. This debate over what has a bigger effect on us has been argued and supported very well from all perspectives. Each side stresses very important details and good explanations for why nature, nurture or self-determination controls how we develop. Experimentation and research has been conducted on these three sides, and each is strongly supported with theories as to why each has an important influence on people. Today, it is generally accepted that these three interact in the formation of who we are, with each playing a critical role.

Nature is believed to be what determines our personalities, looks, and other things because it is all genetically passed down. Any matter concerning traits relies upon the concept of inborn biology. Many=- parents believe that any bad trait that their child has obtained is because of bad parenting, but it may be more a matter of biology and genes that run through the family. It has been concluded that a newborn does not have a blank slate of personality, but rather, has a set of inherited traits. Tests have been done at the University of Wisconsin to show that temperaments of an infant are influenced more by biology than experiences with their siblings.

In a way, nature is our genetic gift, which gives us physical traits such as hair color, eye color, and form of the body. It also determines the kinds of emotions and motivations we will experience, which can be endless. Any new emotion is not possible to experience unless there is change to our genetic material. So in a way, genes give us certain traits or behavior characteristics; but it is all a matter of whether or not we carry out our certain inherited qualities. And our environment (nurture) can sometimes make that choice for us.

The other side of the debate claims that nurture is the cause to our behavior as well as characteristics. Even though genes are what give us that certain spunk to our personality, the environment has the power to alter it and make us into the exact opposite, as some say. Even the way that certain children are brought up can change

how they turn out. Many theorists, including behavioralists, regard learning from our environment as the key to our personal development.

From the existentialist's perspective, it is the ability to choose that makes us human and sets us apart from animals. We have the ability to transcend our experience and make decisions about our behavior and future. We have a say in our self-determination. We find inspiring examples of people who have developed in spite of their lack of environmental support and meager beginnings.

Special Note: All data sources included in the presentation are referenced on the Facilitator Reference Guide 2: Background Research and References. Where specific data is reported in the presentation, you should find the general reference in this guide.

💻 Slide 13: Biological Factors

- Birth disorders
  - Developmental Delays and Disabilities
    - Cognitive Disabilities
    - Downs Syndrome and other genetic disorders
  - Physical defects and birth disabilities
- Injuries:
  - Traumatic Brain Injuries
  - Spinal Cord and other major physical disabilities

Nature is not always fair and some children and families have been given more to deal with than others. Medical science has radically improved and children that would have died fifty years ago are now living. Unfortunately, while medical science has been able to preserve life, it has not always been able to restore quality of life.

💻 Slide 14: Biological Factors, Continued

- Biologically based Mental Health Disorders
  - Schizophrenia, paranoia and other psychotic disorders
  - Schizoaffective disorder
  - Major depressive disorder
  - Bipolar disorder
  - Obsessive-compulsive disorder
  - Panic disorder.

In the mental health arena these are the generally accepted mental health diagnoses that have a biological basis. That does not mean that 100% of the cause is attributed to genetics, but individuals with these disorders inherit the genetic predisposition for these disorders. Environment may still have played a factor but the chance of developing these disorders was biologically determined.

💻 Slide 15: Biological Factors, Continued

- 9% of Colorado's children are estimated as having a serious emotional disturbance. This represents nearly 100,000 Colorado children. Over 60% of all young people with mental illness are not getting the treatment help they need.
  Reference: The Federation of Families for Children's Mental Health website.
- Colorado's teen suicide rate is 3.37 per 100,000 with approximately 47 youth suicides annually (Colorado ranks the sixth worse rate nationally with more adolescent suicides annually than either homicides or automobile related adolescent deaths).
  Reference: "Suicide in Colorado", published by the Colorado Department of Public Health and Environment.

💻 Slide 16: Biological Factors, Continued

- Development is sequential
  - Physical development creates opportunity for learning
  - Brain development
    - Largest mass at 9 months
    - Increasing specialization with development
    - The brain is not fully developed until an individual is in their late 20s
    - The last brain area to develop is the prefrontal cortex which governs judgment
  - Humans are totally dependent on their caregivers as infants and our movement towards self-sufficiency is long protracted process

Before moving onto the next slide, provide a brief overview of learning theory: we learn from interacting with our environment. Some environmental factors are healthy (warmth, safety, security and stability) while some elements are detrimental to healthy development (poverty, family instability/divorce, stress and violence). We are shaped by our experiences and through our continued interaction with our

environment we are constantly learning and changing. The following are some of the environmental factors that shape our experiences: family, culture, environment, and trauma.

Slide 17: Environmental Influences

- We are shaped by our experiences and through our continued interaction with our environment we are constantly learning and changing
  - Family
  - Culture
  - Environment
  - Trauma

:

Slide 18: Environmental Influences

- Colorado's Population ages 0-17: 1,281,607 (*US Census report)*
- Children in Poverty
  - 18.2% for all Colorado Children 233,252
  - Under 5 21%
  - Children 5-17 17.5%
  - All Coloradoans 12.3%

  Reference: Colorado's Children 2011, published by the Child Welfare League of America (2010).
- Number of Homeless Children 21,878

  Reference: America's Youngest Outcasts: State report card on child homelessness
- TANF is increasing
  - 2009 to 2010 the number of families on TANF increased 11.1%
- Children who live in families with annual incomes of less than $15,000 are 22 times more likely to be abused or neglected than those with annual incomes of $30,000 or more.

  Reference: "Child Welfare: Poverty and Families in Crisis", published by the Children's Defense Fund.

The importance of the section is to emphasize that child abuse and poverty are directly correlated. Children living in intensive poverty are much more likely to be abused and neglected than children in families only marginally better off. Poverty is a stressor and does affect families and the children that live within them.

Slide 19: Environmental Influences, Continued

- Children in Poverty and its influence on other factors
  - The Colorado Population in Need Study 2009, found that amongst children and adolescents living at or below 300 percent of the federal poverty level, 49,364 had a serious emotional disturbance and 7,716 had a substance abuse problem in SFY 2006-2007.

Slide 20: Environmental Influences, Continued

- Health Care
  - 329,800 children were enrolled in Medicaid (59.6% of the total Medicaid enrollees and 27.7% of the state child population)
  - 64,598 children were enrolled in Colorado's Children's Health Insurance program (CHIP) (5.4% of the state child population)
  - It is estimated that 10% of children in Colorado have no health care coverage

Reference: Colorado's Children 2011, published by the Child Welfare League of America (2010) and the Colorado Children's Health Insurance Status: 2011 Update.

Slide 21: Environment Influences, Continued:

- Child Abuse and Neglect
  - Referrals in 2009-2010 76,628
    - An 11.9% increase over the previous year
  - Investigations 38,514
    - An 15.9% increase over the previous year
  - New Involvements 13,947
    - An 22.3% increase over the previous year
  - Open Involvements 41,567
    - An 4.5% increase over the previous year
  - 36 Child Fatalities due to abuse

Resource: 2010 Annual Evaluation Report by CDHS Child Welfare

Slide 22: Environment Influences, Continued

- Child Abuse and Neglect
  - County Distribution
    - Big Ten 65.2%
      - 4 Denver Metro 43.2%
    - Balance of State 34.8%
  - Types of Maltreatment
    - Neglect 78%
    - Physical Abuse 15%
    - Sexual Abuse 10%

The presenter should carefully review the above breakdown of cases. It is estimated that approximately 10,900 of new involvements involve neglect, 2,100 involve physical abuse and 1,400 involve sexual abuse. This data becomes very interesting after reviewing the implications of the reports by adults surveyed in the ACEs Study that you will talk about in the following slides.

Slide 23: Environment Influences Graph

This graph shows the percentages of population for the various age ranges and how infant and adolescents cases in child welfare and in out-of-home care are greater. The higher placement levels for certain age groups are attributed to the fact that infants cannot care for themselves and adolescents, as they age, have behavioral problems that are more difficult for families and communities to manage.

Before moving on to the next slides, explain ACEs research (from ACEstudy.org): *The Adverse Childhood Experiences (ACE) Study is a decade-long and ongoing collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Centers for Disease Control and Prevention (CDC). However, some of the concepts for the ACE Study had their beginnings in 1985 when, as a specialist in Preventive Medicine, Dr. Felitti initially set out to help obese people lose weight through the Positive Choice programs. To his amazement, those people most likely to drop out of the weight loss program were those who were successfully losing weight!*

In a careful study of 286 such patients, Dr. Felitti learned that many had been unconsciously using obesity as a shield against unwanted sexual attention, or as a form of defense against physical attack, and that many of them had been sexually and/or physically abused as children. That is to say, although obesity was

conventionally viewed as the problem, it was often found to be the unconscious solution to other, far more concealed, problems. The prevalence and severity of these problems was totally unexpected. Many, like childhood sexual abuse or suicidality, were shielded by social taboos against freely discussing these topics, even in medical settings.

The Adverse Childhood Experiences (ACE) Study is a decade-long and ongoing study designed to examine the childhood origins of many of our Nation's leading health and social problems. The Study represents collaboration between the Nation's leading prevention agency, the Centers for Disease Control and Prevention (CDC) and the Kaiser Health Plan's Department of Preventive Medicine in San Diego, CA.

The key concept underlying the Study is that stressful or traumatic childhood experiences such as abuse, neglect, witnessing domestic violence, or growing up with alcohol or other substance abuse, mental illness, parental discord, or crime in the home (which we termed adverse childhood experiences—or ACEs) are a common pathway to social, emotional, and cognitive impairments that lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability and premature mortality. We now know from breakthroughs in neurobiology that ACEs disrupt neurodevelopment and can have lasting effects on brain structure and function—the biologic pathways that likely explain the strength of the findings from the ACE Study.

During two survey "waves" conducted during 1995 to 1997, 17,337 predominantly well educated, middle-class members of the Kaiser Permanente Medical Care Program in San Diego, California agreed to participate in the Study, as part of a comprehensive medical evaluation. Prospective assessment of the relationships of ACEs to health care utilization, rates of pharmaceuticals prescribed, disease incidence, and causes of death is an ongoing focus of the Study.

The ACE study population included 9,367 (54%) women and 7,970 (46%) men (total sample=17,337). Their mean age was 56 years. Seventy-five percent were white, 39% were college graduates, 36% had some college education, and 18% were high school graduates. Only 7% had not graduated from high school.

The Study assessed 10 categories of stressful or traumatic childhood experiences. The experiences chosen for study were based upon prior research that has shown them to have significant adverse health or social implications, and for which efforts in the public and private sector exist to reduce the frequency and consequences of their occurrence.

Prior research into the effects of childhood maltreatment and related experiences (including witnessing domestic violence) has tended to focus on only one or two categories of experience, such as physical or sexual abuse or domestic violence, and has generally focused on a limited range of outcomes. The ACE Study is unique not only because of its size, but because it was also designed to assess the relationships of a broad range of adverse childhood experiences (ACEs) to a wide range of health and social consequences.

💻 Slide 24: Environmental Influences:

- Adverse Childhood Experiences - *these are the types of adverse childhood experiences surveyed for in the ACEs Study.*
  - Childhood Abuse
    - Emotional/Psychological
    - Physical
    - Sexual
  - Neglect
    - Emotional/Psychological
    - Physical
  - Growing up in a seriously dysfunctional household
    - Witnessing domestic violence
    - Alcohol or other substance abuse in the home
    - Mentally ill or suicidal household members
    - Parental marital discord as evidenced by divorce or separation
    - Crime in the home as evidenced by having a household member imprisoned

💻 Slide 25: Child Abuse

- Emotional/Psychological Abuse
  - 11% of study participants
  - 141,000 children *(Estimate derived from population divided by percentage of reported occurrence). If all of the current children living in Colorado were surveyed as adults this would be the number of adults that reported that they had suffered emotional/psychological abuse as children based on the ACEs results.*
- Physical Abuse
  - 28% of study participants

  - 359,000 children *(Estimate derived from population divided by percentage of reported occurrence.) If all of the current children living in Colorado were surveyed as adults this would be the number of adults that reported that they had suffered physical abuse as children based on the ACEs results.*
- Sexual Abuse
  - 21% of study participants
    - 25% of females
    - 16% of males
  - 269,000 children *(Estimate derived from population divided by percentage of reported occurrence.) If all of the current children living in Colorado were surveyed as adults this would be the number of adults that reported that they had suffered sexual abuse as children based on the ACEs results.*

At this juncture it would be informative to reflect on the low number of confirmed reports versus the much higher number of reports by adults of these significant events. We still live in a society that is radically under reporting abuse. If we assume all 2,100 cases annually are discrete one-time only cases, the numbers of children physically abused still would only suggest 37,800 of our youth would later report being physically abused versus the 359,000 that would be expected based on the ACEs Study results. If we assume once again that all 1,400 cases annually are discrete one-time only cases, the number of children sexually abused suggests that only 25,200 of our youth would later report being physically abused versus the 269,000 that would be expected based on the ACEs Study results. Based on the ACEs findings we are uncovering less than 10% of the problem.

💻 Slide 26: Childhood Neglect

- Emotional/ Psychology Neglect
  - 15% of study participants
  - 192,000
- Physical Neglect
  - 10% of study participants
  - 128,000

💻 Slide 27: Growing up with Serious Family Dysfunction

- Domestic Violence 13% of study participants

- Substance Abuse 27% of study participants
  - Very highly correlated with other factors
  - Correlations escalated when both parents abuse
  - Over 80% of the households where substance abuse was present had at least one other ACE and over 50% had multiple
- Mental Illness 17% of study participants
- Parental Marital Discord 23% of study participants
- Crime in home 6% of study participants

Slide 28: Adverse Childhood Experience

Aces Score	Females	Males	Total
0	31.3%	34.2%	32.7%
1	24.2%	27.3%	25.6%
2	14.8%	16.4%	15.5%
3	10.4%	9.3%	9.9%
4	6.8%	4.8%	5.9%
5 or more	12.5%	8.0%	10.5%

Reference: The Relationship of Adverse Childhood Experiences to Adult Health: Turning gold into lead.

More than two-thirds of the respondents report one or more adverse childhood experience; one in four reported three or more; one in six were exposed to 4 or more; and more than one in ten were exposed to 5 or more. This is especially critical since the effects of these adverse childhood experiences are directly correlated with later health and adjustment issues.

Slide 29: Health Issues Related to ACEs *(higher ACEs score higher later incidence)*

- Heart Disease
- Diabetes
- Lung Disease
- Obesity
- Unintended pregnancies
- Hepatitis
- Sexually Transmitted Diseases
- HIV and Aids

- Shorter Life Expectancy *(recent reports are suggesting 20 years shorter life expectancies)*
- Greater Chance of premature death
- Broken bones and fractures

Reference: "The Relationship of Adverse Childhood Experiences to Adult Health: Turning gold into lead".

These first three results on the slide are all health related but the other issues are interactions of health and choice/decision-making.

💻 Slide 30: Mental Health Issues Related to ACEs

- Addictions
  - Alcohol
  - Substance Abuse
  - IV Drug use
- Smoking
- Depression and Suicide
- Impaired work and school performance

Reference: "The High Cost of Adverse Childhood Experience".

This study found that correlations of ACEs with the following school performance indicators suggested impaired functioning: increased suspensions, more special education classifications, more academic failure and more delinquent recidivism. This study also found that found correlations of ACEs with the following work performance indicators suggested impaired functioning: absenteeism, financial problems and job performance issues.

💻 Slide 31: The Impact of ACEs

This graph is interesting in that it shows the direct correlation between the ACEs and various problems. The more ACEs, the more likely an individual is to suffer from one of the following problems.

BREAK

Allocated Time: 10 minutes

THE NEED FOR SERVICES CONTINUED– STRENGTHS AND CHOICE

Allocated Time: 30 minutes

Increasingly, the field of psychology has moved away from a deficits model of mental health and towards a way to understand personality development. Two individuals experiencing the same stresses can develop very differently; in part, this is due to mitigating circumstances or influences. The next few slides discuss some of the factors that mitigate some of the negative effects of adverse experiences and abuse.

💻 Slide 32: Strengths and Mitigating Factors

- Factors are those currently used in the CANS (Child and Adolescent Needs and Strengths Inventory) and have shown to be strengths and positive indicators of better psychological adjustment:
  - Strong family support, connections, love and respect (biological or adoptive)
  - Positive peer relationships, interpersonal likability and development of close friendships
  - School attendance and achievement of an appropriate educational plan, and/or vocational skills Psychological well-being: savoring skills and coping skills are well developed and demonstrated stress management ability.

It should be noted that one of the major initiatives by CDHS is to reduce the number of children aging out of the foster care system without a permanent connection to someone. This is part of the reason why, having someone in a child's life is an anchor that helps to stabilize the child.

Additionally, building positive peer relationships is important for children, and as a result, many treatment programs focus on social skill development. Building long-term connections is a two way street. In order for a youth to maintain positive connections, it is helpful if they have some social skills. Long-term relationships require work and effort.

Explain that there is a strong connection between academic achievement and later success (we will talk more about this later).

💻 Slide 33: Strengths and Mitigating Factors

- Optimistic and future oriented – *versus pessimistic and self-absorbed, with no delay of gratification.*
- Internal locus of control – *believing you have an influence over the course of your life versus believing you are the mercy of fate.*
- Talents and interests: creative, athletic and/or artistic strengths with personal investment
- Spiritual or religious beliefs and/or involvement
- Community ties and investment
- Relationship permanence and stability – *a critical diagnostic question used with youth is whether they have a best friend and if so how they would describe their relationship. Having a close friend is once again a very healthy characteristic. Youth who did not have close friends or who describe friendships without frequent contact are at higher risk than youth with close personal ties.*

💻 Slide 34: Strengths and Mitigating Factors

- Successful management in current living environment
- Healthy social development
- Positive recreational habits
- Successful school or job functioning
  - No evidence of behavior problems
  - School achievement or job advancement
  - Attends school regularly
- No legal difficulties
- The child is healthy
- No physical limitations
- No problems with sexual development

A good indication of future adjustment is current level of functioning. The more healthy characteristics a youth has, the better the prognosis he/she will have in terms of coping with stress and adverse life events.

💻 Slide 35: Caregiver Strengths

- Good physical health

- Positive mental health
- No substance abuse issues
- Appropriately supervises and monitors dependents
- Active involvement in the provision of care
- Knowledgeable regarding their dependent's needs and strengths

💻 Slide 36: Caregiver Strengths

- Organized and efficient
- Caregiver has sufficient financial and social resources to meet the needs of their child
- The family has stable housing
- The present placement is as safe an environment as could be expected
- Lack of marital/partner violence
- Lack of caregiver posttraumatic reactions
- No evidence of parental criminal involvement

💻 Slides 37: Choices: We are Responsible for the Choices We Make

- Experience obviously accounts for some of the behavior of youth but they are also responsible for their choices, and some people that have experienced horrendous circumstances still make excellent choices.

While some of the choices we make may have been affected by the environment in which we developed, nevertheless, we are responsible for the choices we make and these choices will shape us.

💻 Slide 38: Choices

- Teen Dropout Rates
  - In 2009, 20,000 students ages 16-19 dropped out of school
  - Graduations have declined over 10% since 2003, and the most drastic declines have been with minority groups
  - Colorado's graduation rate in 2009
    - Aggregate 72.4%
    - Female 76.3%
    - Males 68.7%

- Whites 80.2%
- African American 63.7%
- Hispanic 55.5%

Reference: "Graduation Rates for the Class of 2010" from the Colorado Department of Education.

This slide and the ones to follow, highlight the idea that "who we are" intersects with "what we decide to do". In other words, the choices we make affect who we become.

💻 Slide 39: Effects of Dropping Out

- Employment rates of 16-24 year old out-of-school youth in US by educational attainment.
  - HS Dropout 45.7%
  - HS Graduate 68.1%
  - 1-3 years of college 78.8%
  - Bachelors or Higher 86.7%
- Average starting salaries are $9,634 lower for high school drop-out compared with high school graduates.

  Reference: "The High Cost of High School Dropouts: What the Nation Pays for Inadequate High Schools", from the Alliance for Excellent Education.

The positive results of successful school completion are profound, both for society and for the individual.

💻 Slide 40: The Cost of Dropping Out

- If Colorado had graduated all its dropouts this year, they would generate approximately $4.2 billion more over the course of their lifetimes.
- A high school dropout contributes about $60,000 less in taxes over a lifetime.

💻 Slide 41: High School Graduates

- Live longer
- Are less likely to be teen parents
- Are less likely to commit crimes (It is estimated that a 5% increase in male graduation rates would save the nation $4.9 billion annually in crime-related costs)

- Rely on government health care less (Projections estimated that America would save more than $17 billion annually in Medicaid and expenditures for health care for the uninsured by graduating all students).
- Use fewer other public services such as food stamps or housing assistance
- Are more likely to raise better-educated children

💻 Slide 42: Substance Abuse

- National studies reveal that approximately 13.6% of adolescents are using drugs, which suggests 80,000 plus adolescents are drug users in Colorado.
- In 2008, 2,412 adolescents received substance abuse treatment.
- Of the youth committed to the Division of Youth Corrections (DYC) in FY 2007/2008, 67% of the females and 58.9% of the males were assessed as in need of treatment level services.

  Reference: "Annual Report to the Governor of Colorado 2010" by the Colorado Juvenile Justice and Delinquency Prevention Council & Office of Adult and Juvenile Justice Assistance Colorado Department of Public Safety Division of Criminal Justice.

💻 Slide 43: Juvenile Delinquency

- In 2009, 37,890 children younger than 18 were arrested in Colorado.
- An average of 436.8 youth were held in detention daily in Colorado, a 7.4% decrease from the previous year.

  Reference source for this information was the *DYC Monthly Population Report from June 2010.*

💻 Slide 44: Juvenile Justice

- 46 youth were charged as adults in SFY 2009-2010
- 18th Judicial District (Arapahoe) had 21 direct files
- 6th Judicial District (Mesa) had 6 direct files
- The balance of State had 19 direct files with no other judicial district having more than 2

Reference: "Senate Bill 94 (SB 94) Evaluation Annual Report Fiscal Year 2009-10" by the Colorado Department of Human Services Office of Children, Youth and Families and the Division of Youth Corrections

Since the decision to direct file is made by the local DA, an interesting issue is raised regarding this discretion of authority. While not attempting to be controversial, it appears that there is something different happening in the 18th district.

💻 Slide 45: Committed Youth

- Average age at commitment is 16.6 years of age
- The average length of placement was 18.9 months as most youth (99%) received the maximum sentence of two years.
- 1170.6 incarcerated
  - State Operated Facilities 499.1 ADP 44%
  - Private/Secure Facilities 486.8 ADP 42%
  - Community Facilities 184.6 ADP 14%

  Reference: DYC Monthly Population Report from June 2010.

💻 Slide 46: Committed Youth

- Characteristics of Committed Youth
  - Female 14.1%
  - Male 85.9%
  - Race/Ethnicity
    - White 43.0%
    - Hispanic 35.3%
    - African American 18.6%
    - Other 2.9%
- 1269 on parole for some portion of year
- Total ADP (average daily population) 2404

  Reference: DYC Monthly Population Report from June 2010.

💻 Slide 47: Committed Youth

- The Colorado Division of Youth Corrections estimated approximately 22% of the juveniles in its custody had a serious emotional disturbance, 67% have some form

of mental health problem and 86% have substance abuse issues. (MHAC and FFCMHCC, 1999).

ACTIVITY: FREQUENTLY SEEN PROBLEMS

Allocated Time: 30 minutes

💻 Slide 48: Group Activity

Instruct the participants to gather into their previous table groups. Have them discuss the following questions:

- *Identify and share the types of problems you see most frequently in your practice, court or on your caseload?*
- *In your opinion how much of the problem is due to the child's genetics, how much is attributable to the children's experience and how much of the problem is due to the poor quality of choices the youth has made.*

After 15 minutes, have the table groups report back to the large group. Record these answers on a flip chart.

💻 Slide 49: Break for One Hour Lunch and Networking

A CLOSER LOOK AT SERVICES

Allocated Time: 60 minutes

Slides 50-53 take a look at the comparison between computers and people. People are much more complex than computers and much more difficult to fix when something goes wrong. The following joke is way to introduce this concept and at the same time, inject a little humor into the day.

💻 Slide 50: Computers versus People

- Unlike information technology people are not like computers
- Like computers we are hardwired and certain innate abilities and capabilities
- Both computers and people are shaped by interactions with our environment
- But unlike computers people can make decision for themselves and behave in ways that are not always rational

Remember, fixing computers is easier than fixing people

💻 Slide 51: What is my Favorite Computer Joke? ……

💻 Slides 52-53: What Gender is a Computer?

- A national survey of woman concluded that computers are male because:
  - – In order to get their attention, you have to turn them on.
  - – They have a lot of data but are still clueless.
  - – They are supposed to help you solve your problems, but half the time they cause the problem.
  - – As soon as you commit to one, you realize that if you had waited a little longer, you could have had a better model.
- A national survey of men concluded that computers are female because
  - – . No one but their creator understands their internal logic.
  - – The native language they use to communicate with other computers is incomprehensible to everyone else.
  - – Even your smallest mistakes are stored in long-term memory for later retrieval.
  - – As soon as you make a commitment to one, you find yourself spending half your paycheck on accessories for it.

Slides 53-65 take a brief look at the history of child welfare. The child welfare field is relatively new and is still developing and changing. Practice has changed dramatically over the last hundred years and continues to rapidly change today. If you are not familiar with the history of child protection in America, an article like John Myers' "A Short History of Child Protection in America" would be a great place to review some of the history.

💻 Slide 54: Brief History of Child Welfare

- Mary Ellen Wilson (1874) the first abuse case
  - Henry Bergh
  - American Society for the Prevention of Cruelty to Animals
- Henry Kempe and the Battered Child Syndrome 1962
  - 49 states pass child abuse reporting laws
  - Social Security Act amended to fund child welfare
- Child Abuse Prevention and Treatment Act (CAPTA) of 1974 (public law 93-273) expanded federal support for child welfare and lead to the creation of child protective services
  - Included sexual abuse in its definition of maltreatment
  - Sexual abuse was larger invisible prior

💻 Slide 55: History of Child Welfare

- The transition of Orphanages to treatment centers The movement from hospitalization to community based care
  - The Adoption Assistance and Child Welfare Act of 1980 (public law 96-272)
    - Least restrictive and most appropriate
    - Mandated the "reasonable efforts" be made to avoid removing children from maltreating parents (family preservation) and required every child in foster care to have a permanency plan
- Multiethnic Placement Act of 1994 (MEPA) prohibits child welfare agencies from delaying or denying adoptive placements on the basis of race.

The Denver Orphan's Home (Colorado's oldest, founded in 1876) became the Denver Children's Home during its transition from being an orphanage to

becoming a treatment center in the 1960s. During this period, it added treatment professionals and transitioned from live-in staff to shift work.

💻 Slide 56: History of Child Welfare

- Promoting Safe and Stable Families Act of 2001:
  - Educational and training vouchers for youth who age out of the foster care system
  - A mentoring program for those children with an incarcerated parent.
- Foster Connections to Success and Increasing Adoptions Act of 2008
  - Allowed financial reimbursement for kinship care
  - Expanded allowable age until 21 at state discretion
  - Provided for tribal foster care and adoption access
  - Provided states incentives for increasing adoption

💻 Slide 57: Historical Tensions

- The child development field has been historically divided between those who identified the primary needs of youth as children need to be loved and nurtured versus those that believe children need discipline and structure

Society still struggles with what is the proper venue for managing youth as we attempt to determine whether mental health, child welfare, or juvenile justice is the appropriate and most effective venue.

💻 Slides 58-59: Historical Tensions

• Nurturance	Discipline
• Love	Structure
• Acceptance	Education
• Unconditional Positive Regard	Limits
• Warmth	Consequences
• A positive relationship with an adult	Accountability
• Care	A firm hand
• Understanding	A wake-up call

💻 Slide 60: Historical Tensions

- One hundred years ago this played out in the differences between the orphanages and the military academies.
- Today it plays out in the differences between child welfare/mental health and juvenile justice.

💻 Slides 61-63: Historical Tension Two: Individual vs. Systemic Focus

- Individual Focus
  - Focus of intervention is the identified patient
  - Intervention is focused on the child
  - Primary interventions are individual and/or group therapy
  - Emphasis on confidentiality and privacy
- Systemic Focus
  - Focus of intervention is the family
  - The need for intervention is defined as a system issue to which all contribute
  - Primary intervention is family therapy
  - Emphasis on engagement

Explain that historically there has been a tension between the individual patient and the family system with regard to treatment and intervention. Especially in work with youth, a focus on individual treatment produced mixed results at best. Even as youth developed individual skills, a return to their home environment often resulted in decompensation and a return to old ways of behaving. In part, this is because the family/environment did not support the new ways of behaving.

Research shows a critical component of residential treatment is the support and commitment of the family.

Also note that an even boarder systemic view focuses on the community

💻 Slides 64-66: Individual vs. Systemic Focus

- One-hundred-and-fifty years ago wives and children were considered property and the rule of thumb applied.
- What responsibility do parents have today for the behavior of their children?

Estimates place parental substance abuse at between 50-90% of all child welfare cases.

💻 Slide 67: Out-of-home Placement

Slides 67-122 discuss the Colorado experience of children within the child welfare system.

- 11,905 children in placement – a 9% decline from the previous year
  - Foster Care 48.5% 19% decline
  - Kinship Care 25.06% 26% increase
  - Residential Care 18.69% 16% decline
    - Includes DYC community placement population
    - Does not include any BHO or child mental health treatment placements
    - PRTFs (Psychiatric Residential Treatment Centers) minimal utilization – *currently average utilization for PRTFs is less than 3 youth per day*
  - Group Home 6.36%
  - Independent Living 1.4%

Reference:"2010 Annual Evaluation Report CDHS, Division of Child Welfare (2010)".

💻 Slide 68: Out-of-home Population Rationale

- **Environment**
  - Neglect 20%
  - Parent drug/alcohol abuse 18%
  - Caretaker inability to cope 14%
  - Physical abuse 7%
  - Incarceration of Parents 6%
  - Inadequate housing 5%
  - Sexual abuse 4%
  - Abandonment 3%
- **Child Choices**
  - Child's behavior problem 18%
  - Child drug/alcohol abuse 4%
  - Child's disability 1%

Reference: Report made to the Child Welfare Action Committee in 2008 prepared by the Division of Child Welfare.

Age plays a role here, as younger children are more likely placed out of the hone because of parental issues like neglect, whereas adolescents are more likely to be placed out of the home due to their own behavior issues.

Now let's move into a discussion regarding the child welfare program areas. Slides 69-78 provide an explanation of these areas. The majority of children served fall into three program areas.

Slide 69: Program Area 4 - Youth in Conflict

- Program Area 4 services are provided to reduce or eliminate conflicts between youth and their family members or the community when those conflicts affect the youth's well-being, the normal functioning of the family or the well-being of the community.
- The focus of services shall be on alleviating conflicts, protecting the youth and the community, re-establishing family stability, or assisting the youth to emancipate successfully.

  Reference: "2010 Annual Evaluation Report CDHS, Division of Child Welfare (2010)".

Slide 70: Child Welfare Population

- Program Area 4 Youth in Conflict ($46,350,77)
  - 13% of Child Welfare Services
  - Mostly older
  - Out-of-Home $37 million
    - Foster Homes $7 million
    - Residential $27 million
    - RCCF & Other $3 million
  - Core Services $9 million
  - Subsidized Adoption $300 thousand

Slide 71: Program Area 5 – Child in Need of Protection

- Program Area 5 services are provided to protect Children whose physical, mental or emotional well-being is threatened by the actions or omissions of parents, legal guardians or custodians, or persons responsible for providing out-of-home care, including foster parent, an employee of a residential child care facility, and a provider of family child care or center-based child care.
- The county shall provide services targeted to achieve the following: children are secure and protected from harm; children have stable, permanent and nurturing living environments; and, when appropriate, children experience family continuity and community connectedness.

💻 Slide 72: Program Area 5 – Child Welfare Population

- Program Area 5 Children Protection ($71,536,665)
  - 48% of Child Welfare Services
  - Mostly younger
  - Out-of-Home $54 million
    - Foster Homes $27 million
    - Residential $14 million
    - RCCF & Other $10 million
  - Core Services $18 million
  - Subsidized Adoption $400 thousand

💻 Slide 73: Program Area 6 – Children in Need of Specialized Services

- Program Area 6 services are statutorily authorized services to specified children and families in which the reason for service is not protective services or youth in conflict.
- These services are limited to children and families in need of subsidized adoption or Medicaid-only services, or to children for whom the goal is no longer reunification.
- The purpose of services in Program Area 6 is to fulfill statutory requirements in the interests of permanency planning for children.

💻 Slide 74: Program Area 6 – Child Welfare Population

- Program Area 6 Specialized Services ($77,213,163)
  - 35% of Child Welfare Services
  - Out-of-Home $34 million

    - Foster Homes $3 million
    - Residential $6 million
    - RCCF & Other $4 million
  - Core Services $2 million
  - Subsidized Adoption $42 million
- Other 4%

Slide 75: Graph of Child Welfare Expenditures by Program Area

Note the differences in placement patterns based on the program areas/needs of the case. Residential care is most utilized by youth in conflict, foster care is the primary invention for youth in need of protection, and subsidized adoption is most frequently used for special need populations. Remember the match between services and needs. Often youth in conflict have greater needs for containment and treatment.

Slide 76: Graph of Program Are Services Distribution

This graph shows the case distribution between out-of-home care and CORE services by program area.

Slide 77: Graph of Residential Child Welfare Placements

This graph is program information demonstrating the decline in residential care. This trend is partly the result of funding decreases and partly a philosophical shift towards more community based treatment. This is also called wrap-around services due the fact that services are wrapped around the individual in their environment rather than removing them from it. The information for this graph comes from the author of this curriculum's personal records based on reports from the Department of Human Services that he has collected for the last ten plus years.

Slide 78: Human Services Placement Numbers

- Number of Children in Foster/CPA Group Homes: 5,922
- Number of Children in Kinship and Other Care: 4,054
- Number in Residential Care (CW & DYC): 1,929
  - Children in Residential Care Child Welfare only: 658
- Number of Finalized Adoptions: 1,033
- Number of Children in Core Services Programs: 15,226

Reference: "2010 Annual Evaluation Report CDHS, Division of Child Welfare (2010)". The 11,905 of children in placement is 9% less than the previous year.

Now let's move into a discussion about CORE services. CORE services are intended as an alternative to out-of-home care or to prevent out-of-home placement.

Slide 79: Core Services

- The Core Services Program was established within the Colorado Department of Human Services in 1994 and is statutorily mandated to provide strength-based resources and support to families when children are at imminent risk of out-of-home placement and/or are in need of services to maintain a least restrictive setting.

Slide 80: Core Services Numbers

- 11,905 children were in Foster Care versus 15,226 in CORE Services
- 5% decline in last year in the number of children served in CORE Services
- $45,456,711 in services provided SFY 2009-2010
- Only 8% of children receiving CORE services in spite of being at risk for out-of-home placement were placed out-of-home.
- Only 3% of families receiving CORE services had a founded report of child abuse during the period they were receiving services and only 2.5% had a founded report of child abuse in the 12 months following receiving services.

  Reference: "CORE Services Program Evaluation Annual Report SFY 2009-2010" prepared by the Colorado Department of Human Services Office of Children, Youth and Families, Division of Child Welfare.

Slide 81: Utilization by County

County	2008	2009	2010
Denver	18.5%	17.4%	14.4%
Larimer	10.5%	11.9%	12.2%
El Paso	9.1%	10.2%	10.4%
Arapahoe	11.3%	8.6%	10.3%
Jefferson	9.7%	9.6%	9.6%
Adams	6.3%	5.7%	7.7%

These numbers reflect the percentage of the state total used by the county. As you can see the size of the county is the only factor driving utilization of CORE services. Larimer County has made a concerted effort to move in this direction and utilizes at a greater rate than its size would suggest.

Slide 82: Graphic breakdown by racial background

This slide provides information on the racial utilization of services. Note the higher percentage of open cases for whites and Hispanics, and the higher utilization of services by Hispanic populations.

Slide 83: Typical Core Service Programs

- Designated types of services by frequency on use
  - Substance Abuse Services (over 25%)
  - County Designated Services (22%)
  - Mental Health Services (16%)
  - Life Skills (8%)
  - Home Based Intervention (8%)
  - Intensive Family Therapy (8%)
  - Special Economic Assistance (6%)
  - Sexual Abuse Treatment (3%)
  - Day Treatment (2%)
  - Aftercare (<1%)

Reference: "CORE Services Program Evaluation Annual Report SFY 2009-2010" prepared by the Colorado Department of Human Services Office of Children, Youth and Families, Division of Child Welfare.

Slides 84-87: Core Service Programs Utilization

This chart is included as an appendix and is part of the Core Services Annual Report published by CDHS. It shows which counties purchased these CORE service programs during the 2009-2010 State Fiscal Year. While many services are almost uniformly available and utilized, others are not available in specific locals (especially day treatment and aftercare).

Slide 88: Other Child Welfare Programs

- Autism Waiver
- Children's Extensive Support Waiver
- Home and Community-Based Support (HCBS) Waiver for Persons with Brain Injury
- Children's Habilitation Residential Program Waiver

Autism Waiver: This provides Medicaid benefits in the home or community for children with a medical diagnosis of Autism who are most in need due to the severity of their disability. It applies to children medically diagnosed with Autism with intensive behavioral needs who are at risk of institutionalization. Children are eligible for this program from birth through age 5. Children must meet additional targeted criteria.

Children's Extensive Support Waiver: The purpose of this waiver is to provide Medicaid benefits in the home or community for children with developmental disabilities or delays, that are most in need due to the severity of their disability. Children are eligible from birth through age 17. The populations included in this waiver are those requiring an intermediate care facility for the mentally disabled and children with intensive behavioral or medical needs that are at risk of institutionalization. Children, birth through age 4, must have a developmental delay. Children, 5 through 17, must have a developmental disability.

HCBS Waiver for Persons With Brain Injury: The HOPEFUL Program: This waiver provides access to Medicaid services for children with a life-limiting illness. The HCBS Pediatric Hospice Waiver (HCBS PHW) is for children from birth to age nineteen with a medical diagnosis of a life-limiting illness who meet the institutional level of care for inpatient hospitalization. The HCBS PHW allows children to live in their community while keeping them out of institutions. Eligibility includes the following: must have a diagnosis of a Life-Limiting Illness certified by a physician and must not have reached 19 years old; are determined financially eligible for Medicaid by the local County of Social/Human Services; are determined to meet Social Security Administration definition of disability; are at risk of institutionalization into a hospital as determined by the SEP case manager using the ULTC 100.2 and physician's statement; and are determined by the case manager to be safely served in the community, They receive at least one HCBS-PHW waiver benefit per month to maintain enrollment in the waiver

Children's Habilitation Residential Program Waiver: The purpose is to provide a home or community based alternative to hospital or specialized nursing facility care for persons with brain injury. Applies to those between the ages of 16 and 64. Persons with brain injury as defined in the Colorado Code of Regulations with specific diagnostic codes. They require hospital or nursing facility level of care.

See Appendix C for a complete list of services

ACTIVITY: GEOGRAPHY MATTERS

Allocated Time: 30 minutes

💻 Slide 89: Geography Does Matter

As a large group, facilitate a discussion around the following questions from Slide 89:

- *Geography obviously has an impact on the availability of services, as well as the ability of people to access them.*
- *What steps can be taken in your community to overcome any barriers to service availability?*

As participants provide answers, record their answers on the flip chart. Instruct participants to also be taking notes as other participants provide ideas and opportunities for overcoming the barriers that families in the child welfare system may encounter while finding available services. Possible areas for exploration may include identification of client needs and discussions with local non-profits regarding service development. More formal processes might include the development of an RFP (Request for Proposal) or RFI (Request for Interest).

10-MINUTE BREAK

After wrapping up the discussion, give the participants a 10-minute break.

OTHER ENTRY POINTS FOR SERVICES

Allocated Time: 50 minutes

💻 Slides 90-91: Other Entry Points for Services

- Private Insurance
- Mental Health
  - Hospitalization
  - OOH care
  - Outpatient and Community-based Services
  - Children's Mental Health Treatment Act
- Education
  - Early Intervention Programs
  - Alternative Education Programs
  - Special Education Services
  - Direct placements in Day Treatment
  - EARSS (Expelled and At-Risk Student Services)
- Public Health
  - Tony Grampus Youth Service Programs (TGYS)
  - Colorado Children's Trust
    - Prevention Programs
    - Early Intervention Programs
- Youth Corrections/Juvenile Justice
  - Juvenile Diversion *(to reduce commitments)*
  - SB 91-94 *(to reduce detentions)*
  - Detention
  - Commitment
  - Parole
  - Direct files *(trying children as adults)*

Private Insurance: About 50% of youth are in families with some type of medical insurance. While parity legislation has increased mental coverage for many disorders, mental health coverage still tends to minimal and limited to certain disorders and certain treatment procedures. Psychiatric hospitalization is covered, but there are minimal benefits for residential or intensive outpatient services. The result is that many families and individuals in need end up turning to government for help.

💻 Slides 92: Mental Health: BHO Capitated Services

- Medicaid Capitated Services: for Medicaid eligible Children (either because of family poverty, disability or because of enrollment in out-of-home care)
- Behavioral Health Organizations (BHO) are responsible for providing eligible services to youth in foster care system. The five BHOs are:
  - Access Behavioral Care
  - Behavioral Health Care Inc.
  - Colorado Health Networks
  - Foothills Behavioral Health Partners
  - Northeast Behavioral Health Partnerships

Contact information of the BHOs can found in Appendix D

💻 Slides 93-94: Mental Health (*The following list of services came from a review of the BHOs' websites)*

- Services available for covered diagnoses through Medicaid
  - Psychiatric Hospitalization
  - Residential services
  - Outpatient services
    - Assessment, evaluation and diagnostic services
    - Traditional and enhanced individual, family and group therapy available in a variety of settings including services in some school based clinics
    - Medication evaluation and management
    - Crisis intervention and suicide prevention counseling
    - Case management, care coordination, and referrals
    - Therapeutic day treatment program
    - Intensive in-home family therapy services
    - Drop-in Centers
    - Alcohol and drug treatment and educational programs
    - Career counseling
    - After-school programs
    - Mentoring programs
    - Parenting education programs
    - Prevention programs
    - Child care consultation

- Special need camps

💻 Slide 95: Psychiatric Hospitals Serving Children and Adolescents

- Centennial Peaks
- Children's Hospital
- Colorado Mental Health Institute Pueblo
- Colorado West Psychiatric Hospital
- Denver Health
- Highlands Behavioral Health
- Mountain Crest Behavioral Healthcare Center
- Parkview Hospital

This is the current list of open facilities (Note: a new hospital is underdevelopment in Colorado Springs).

💻 Slides 96: Psychiatric Hospitals Serving Children and Adolescents

- In the 1990s over 700 psychiatric hospital beds closed for children and adolescents, and most of the cases formerly managed at the hospital level of care are now managed by residential treatment providers.
- This trend has continued with the closure of the recent Fort Logan's Child and Adolescent units.
- Today, less than 200 Psychiatric hospital beds exist for youth and less than 35 a day are filled with publicly funded clients most of the hospital utilization is private pay.
- In reality BHOs fund few residential placements.

Where are the services for intensive mental health needs? There have been major declines in psychiatric hospitalization and residential care and increased mental health treatment needs in DYC.

💻 Slide 97: Mental Health Treatment Act

- SB 07-230 Children's Mental Health Treatment Act formerly known as HB 99-1116 was designed to address the issue of services for children. Prior to this legislation, families were often subjected to unnecessary legal and system involvement, and frequently required to relinquish custody of their child solely to

obtain necessary mental health services for their children even in cases where no abuse or neglect was present.

This program was originally created by Representative Moe Keller in response to the complaint that families with a high-need, mentally ill youth were being required to voluntarily stipulate to a Dependency/Neglect petition and relinquish custody of their children in order to acquire services in spite of the fact they were fit parents.

Slide 98: Children's Mental Health Treatment Act

- This act clarifies the process of how families can:
  - Access services for "children at-risk of out of home placement" without D & N action; and
  - How children covered under the Medicaid capitation program can access residential services and resolve complaints regarding services offered
- A "child at-risk" is defined as:
  - One who has a mental illness, is not categorically eligible for Medicaid;
  - Requires residential level of care or a community-based equivalent; and
  - Qualifies for Supplemental Security Income (SSI) if residential care is needed

Reference: "Child Mental Health Treatment Act Annual Report", July 2009-June 2010.

Slide 99: Children's Mental Health Treatment Act

.

- In Fiscal Year 2009-2010, the program served 55 youth, compared to 44 youth served in FY09; 48 received community-based services; and 33 received residential services. *Residential utilization has become more problematic since the 2006 change in reimbursement through Medicaid for facilities.*
- The CMHTA program received a sum of $275,886 in Tobacco Settlement Funds, which was spent on direct services to children served in the program.
  - $76,619.97 for community alternative services (for children who only received community-based services)
  - $570,224.56 for residential services
  - $127,367.93 for transitional (post-residential) services
  - $30,459.55 for case management

Reference: "Child Mental Health Treatment Act Annual Report", July 2009-June 2010.

Slide 100: Programs in Schools

- Early Intervention Programs
  - Part C for children ages 1-3 with developmental delays
  - Part B for children ages 3-5 with developmental disabilities
- School Based Services
  - Special Education
  - Alternative Education Programs
  - Direct Placements into Day Treatment
  - School Based mental health treatment
    - Counseling Services through educational funding streams
    - BHO operated School Based Services

Slides 100-101: Education Funded Services

- EARSS (Expelled and At-Risk Student Services)
  - 8 program sites for at-risk and expelled students
  - Established by C.R.S. §22-33-205 in 1996.
  - Served 10,185 students (18% increase over the previous year)
  - In 2009-2010, 100,045 students were suspended
    - 10% has been expelled (969) and the other 90% (8,824) were at-risk of expulsion
    - Primary causes of expulsion:
      - 7% drug violations
      - 20% detrimental behavior
      - 15% weapons
    - Primary reason students are classified as at-risk:
      - 48% truancy
      - 20% detrimental behavior
      - 12% disobedience
      - 7% alcohol and tobacco

Reference for the next three slides: "Expelled and At-Risk Student Service Grant, Evaluation Report to the Colorado Legislature, Grant Award Period: July 1, 2009-June 30, 2010".

Slide 102: Breakdown of students served

	Expelled	At-Risk

Male	82%	56%
Female	18%	44%
White	49%	41%
Hispanic	36%	47%
African-American	10%	8%
Special Ed	13%	14%

Slide 103: EARSS Programs

- Mentoring
- Mental Health Counseling
- Wrap-around
- Restorative Justice
- Substance Abuse Education and Counseling
- Case Management
- Afterschool Programs
- Family Engagement
- Vocational Services

Note the similarity of services with the Human Service Programs.

Slides 105-106: Public Health Services: Tony Grampsas Youth Services (TGYS)

- Tony Grampsas Youth Service Programs in 2010-2011 - The Tony Grampsas Youth Services (TGYS) Program is a program authorized by §25-20.5-201 through 205, C.R.S. and intended to provide funding to community-based organizations that serve children, youth and their families with services designed to reduce youth crime and violence and to prevent child abuse and neglect.
- For fiscal year 2009-10, the TGYS Program was initially appropriated $3,992,530 in Master Settlement Agreement Tobacco funds and $1,000,000 in General Funds. Due to 2009-10 General Fund reductions in the state budget, the TGYS Program's General Fund allocation was eliminated, reducing TGYS funding from $4,992,530 to $3,992,530. Additionally in partnership with the Colorado Children's Trust Fund and the Colorado Youth Development Team the TGYS Program submitted a collaborative application to the Department of Human Services Statewide Strategic Use Fund. The application was funded for $1,000,000, of which $477,602 was specifically for the TGYS Program. Ninety-

four grantees representing 145 agencies were funding in this second year of a three year grant cycle.

💻 Slides 107: Types of TGYS Programs

- Substance abuse education
- Early education and prevent
- Home visitation programs like Parents as Teachers
- Mentoring programs
- Drop-out prevention
- Afterschool Programs
- Boys and Girls Clubs
- Mental health counseling
- Alternative education
- Bullying prevention
- Crime, violence, teen domestic violence and gang prevention
- Teen homelessness

Once again, note the similarity of services with the Human Service Programs.

💻 Slides 108: Colorado Children's Trust

- The purpose of the Colorado Children's Trust Fund is to prevent child abuse and neglect through the funding of family resources centers and prevention home visitation programs. Funding is derived from the dissolution of marriage docket fee and federal funding streams.

💻 Slides 109: Colorado Children's Trust

- Funding is derived from the dissolution of marriage docket fee. Other funding may be obtained from federal grants, contributions, gifts, bequests and private donations.

💻 Slides 110: Colorado Children's Trust

- Funds prevention and early intervention programs
  - Family Resource Centers

- Early Care and Education Programs
  - Parenting Education Programs
- Strengthening Family Initiatives
- Home Visitation Programs
  - Parents as Teachers

💻 Slide 111: Juvenile Justice: SB 91-94 Programs

- Statute states that SB94 monies are to be expended **for services intended to prevent juveniles from being held in detention or commitment facilities or to reduce the time juveniles are held in facilities**. (13) Senate Bill 91-94 created state statute that provided the basis for a "detention continuum." The initiative, still referred to as "Senate Bill 94", provides structure and funding to local jurisdictions for a continuum of services designed to ensure that youth are supervised/incarcerated at a level that is commensurate with their risk to the community.

This bill was the companion legislation to the hard cap on juvenile detention beds.

💻 Slide 112: SB 91-94 Programs

- Supervision (45.6% of expenditures)
- Client assessment and evaluation services (26.3% of expenditures)
- Treatment Services in the community (10.6% of expenditures)
  - Substance Abuse
  - Mental Health
  - Intensive Programs
  - Education/Vocation Support
  - Client/Family Assistance
  - Community Based Placements and Shelter Care
  - Community Service Programs

Reference:"Senate Bill 94 Reference Manual Colorado Department of Human Services Division of Youth Corrections" and the "Report of the State Auditor, Senate Bill 91-94 Program, Division of Youth Corrections, Department of Human Services Performance Audit, November 1999".

💻 Slide 113: Juvenile Diversion Programs

- Prevention Council (Juvenile Justice and Delinquency Prevention Council - JJDPC) funded juvenile diversion programming for a total of 2,615 youth served through 22 programs. Of the youth served:
  - 65% were male
  - 35% were female
  - 55.2% White/Caucasian
  - 28.3% Hispanic/Latino
  - 3.3% Black/African American
  - 3.0% Native American
  - 0.9% Asian/Pacific Islander
  - 5.1% other.
  - 11.2% were ages 10-12
  - 25.9% were ages 13 or 14
  - 63% were ages 15 or older.

  Reference source for the information on the next four slides was the "Annual Report to the Governor Colorado 2010 by the Colorado Juvenile Justice and Delinquency Prevention Council & Office of Adult and Juvenile Justice Assistance Colorado Department of Public Safety Division of Criminal Justice".

Slide 114: Juvenile Diversion Programs

- A total of 1,532 youth exited diversion programs during the reporting period.
  - 82% being successful
  - 3.0% unsuccessfully terminating due to an arrest on a new offense
  - 11% unsuccessfully terminating due to non-compliance with their diversion contract
- A total of 29,526 community service hours were completed by diversion program participants and $229,058 in restitution collected.

Slide 115: Juvenile Diversion Programs

- For the youth served in the program the most prevalent level of charge for which youth were referred were:
  - Misdemeanors (62.5%)
  - Felonies (22.1 %)
  - Petty offenses (10.1 %)

- Status offenses (2.4%)
- Theft (26.3%)
- Person crimes (22.2%)
- Property offenses (20.4%)
- Drug crimes (18.1 %)

💻 Slides 116-117: Juvenile Diversion Programs

- Diversion Programs because they are blended grant, county and private funds and therefore have tremendous variability and include in various judicial districts:
  - Individual and Family Therapy
  - Drug screenings
  - Alternative Schools
  - Wraparound services
  - Animal Assisted Therapy
  - Art Therapy
  - Gender specific, strengths based prevention programming
  - Restorative Justice programming
  - Evidence-based school curriculum
  - Substance abuse and co-occurring disorders treatment
  - Trauma treatment
  - EMDR
  - Non-violent life skills training
  - Case management supervision
  - Offense-specific program
  - Screening and assessment services
  - Programs to address Sexting and Cyber-Bullying.
  - Bullying interventions for and teen-on-teen harassment mediation
  - Behavioral health services
  - Minority family advocate

💻 Slides 118-119: DYC Continuum of Care Programs

DYC Continuum of Care Services (percentages based on budget expenditures)

- Community Transition 44.1%
- Job/Skills Training 14.9%
- Family Services 7.4%
- Independent Living 6.9%

- Family Therapy (FFT & MST) 5.2%
- Experiential Therapy 4.9%
- Individual Therapy 4.4%
- Offense Specific Treatment 3.8%
- Advocacy and Case Management 2.0%
- Restorative Justice 1.8%
- Specialized Assessment and Evaluation 1.4%
- Evidence-based Behavior Training 1.1%
- Day Treatment 1.1%
- Substance Abuse Treatment 1.1%
- Group Therapy 0.1%

Reference: "DYC Monthly Population Report".

💻 Slide 120: A Look at County Based Programming across systems

This chart is included as an Appendix and was developed by comparing the services across the presentation. What is of particular interest is the tremendous overlap of programs across the various funding streams. How much is spent on the infrastructure supporting these various bureaucracies?

- *Admission procedures*
- *Protocols and policy manuals*
- *Billing and accounting functioning*
- *Case managers*
- *HR departments*
  Information tracking systems
- *Accountability and reporting systems*

Most of the system is defined as an attempt to prevent something:

- *Dropping out of school*
- *Delinquency*
- *Detention*
- *Out-of-home placement*
- *Mental health high-end utilization*
- *Parents having to give up custody*

What is troubling is the inability of clients to move easily from funding source to funding source and the impossibility of easy family navigation. Siblings with identical needs can be differentially approved for a program while the other is denied.

Slide 121: The problem with silos

- Each of these funding streams is discreet and limited in who can access the services through these programs

Slide 122: 1451 Collaboratives

- HB04-1451 was designed to encourage county departments of social services to enter into memorandums of understanding (MOUs) with other agencies and departments to coordinate services for children and families.

The problem is that not all collaboratives include all the programmatic areas. Even when these stakeholders are all at the same table, most of them have not figured out a way to provide comprehensive services or integrate care.

Slide 123: Other Indirect Family Supports

- Food assistance programs
- Housing assistance programs
- Medicaid and Chip health care

Most of child welfare programs are related. As discussed earlier poverty, and physical health care are directly correlated to family well-being and functioning.

Slide 124: Other Community Supports

- CASA
- Family support and extended family support
- Community supports and resources
- Faith Based Organizations
- Physical Health Care Providers
- Non-profit organizations
- Boy's and Girl Clubs
- Mentoring groups like Denver Kids, Partners and Big Brothers and Big Sisters

ACTIVITY: NEEDS IN YOUR COMMUNITY

Allocated time: 20 minutes

💻 Slide 125: Group Discussion Question

Instruct the participants to gather into their table groups again to examine and discuss the following questions from Slide 125:

- *Identify the efforts within your community to create collaboration across the continuum of care for child and adolescent services*
- *Identify one step that you could initiate to further this work*

After 15 minutes reconvene as a large group and share possible action steps.

Emphasis should be placed on increasing collaboration and joint problem-solving. While we currently have 33 counties in which 1451 Collaboratives have been established, almost half of the state still has not adopted this practice. Additionally, across system discussion and planning should be encouraged. This includes the private sector agencies as well as governmental agencies.

CONCLUSION AND WRAP UP

Allocated Time: 30 minutes

💻 Slides 126-128: Evidenced Based Programs

- Evidence-based practice (EBP) in is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.
- This definition of EBPP closely parallels the definition of practice adopted by the Institute of Medicine (2001, p. 147) as adapted from Sackett and colleagues (2000). The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case, formulation, therapeutic relationship, and intervention.—Adopted by APA Council of Representatives, August 17, 2005

💻 Slide 129: More EBPs

- SAMSHA's National Registry of Evidence Based Practices currently list 197 mental health interventions
  - MST – Multisystemic Therapy
  - FFT – Functional Family Therapy
  - FAST – Families and Schools Together
  - EMDR – Eye Movement Desensitization and Reprocessing

💻 Slide 130: Evidenced Based Programs

- Issues with EBP
  - Study sample does it match your client population?
    - How similar is the test population to the population you want to apply to it?
    - Many EBPs have not been researched cross culturally
  - Is the program doing the model with fidelity?
  - Evidenced informed practice
    - Based on empirical evidence, certain practices may look promising even though the research on the specific population or application may be lacking or in incomplete form.

Evidence based practice is still an evolving field and many practices have not been fully evaluated, including many county child welfare practices. In addition, many practices have lots of confounding variables making simplistic interruption difficult.

💻 Slide 131: Applying EBP in the Real World

- Treatment professional must balance the desires of
  - Clients
  - Funders
  - County or DYC caseworkers
  - Private Insurance Companies
  - BHOs
  - Courts
  - Monitors
  - Accreditation Bodies

💻 Slide 132: Final Thoughts

- The frustration of families accessing services
- The frustration of providers
  - Demands for faster and cheaper
  - Desire to do better
  - The need for new interventions with families with resulting refocusing away from individual interventions

While we have a broad array of service in Colorado, each silo has its own eligibility criterion, and therefore, even within the same family one sibling might be eligible for a service that another is not.

Providers are treating higher acuity clients faster with fewer resources, but this may mean that the needs of the children are sometimes ignored in the rush to return home.

However, despite these frustrations, emphasize the need to be more creative in thinking about how to better serve families in the child welfare system. Tell participants to reflect on the information presented today and the discussions amongst each other. As you move into the next slide, ask participants what they will take away from this training.

💻 Slide 133: Final Chance for questions and the sharing of what people are taking away from this session.

- Any questions?
- What takeaways do you have from today's presentation?

Instruct participants to complete the course evaluation form. Thank the audience for their participation and attendance. Provide presenter contact information on the final slide and let the participants know that you are open to questions later.