



## **Children's Summit III:**

### ***Public Agency Partnerships to Serve Children and Their Families***

**California Institute for Mental Health  
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## EXECUTIVE SUMMARY

### May 24 & 25, 1999: Leaders Convene

Beginning in 1997, on behalf of the California State Department of Mental Health (DMH) and the California Mental Health Directors Association (CMHDA), the California Institute for Mental Health (CIMH) has convened a yearly Children's Policy Summit. The Children's Policy Summit is an opportunity for state and county mental health departments to set direction and priorities for the upcoming year.

Invitations for the 1999 event went to leaders in other systems serving children, as well as leaders in the mental health system. Attendees included family representatives along with representatives from education, early childhood, child welfare, juvenile justice, healthcare, public health, alcohol and other drug services, and mental health services. There were senior level state officials as well as leaders from large and small counties throughout California.

### Shared Vision

Summit III was planned as an opportunity for exploration, dialogue, development of a shared vision, and action planning. While there is much more to be done, a **preliminary vision** was expressed by those attending:

***We strive for health as a positive state of being.***

***Toward this end, children in any child and family serving system who have mental health needs are identified early and provided with mental health services that:***

- ***support families, are family-centered and strength-based;***
- ***are clinically appropriate and community based;***
- ***are culturally sensitive and competent;***
- ***are coordinated with services from other systems (healthcare, public health, child welfare, alcohol and other drug services, education, juvenile justice, developmental disabilities) with families as equal partners; and***
- ***are delivered seamlessly, no matter through what door the child/family enters.***

### Common Goals

Families and children are well served when all systems work together with them to achieve the desired result. To reach this vision of the future, there have to be common goals and changes in many aspects of how these public systems serve

children and families. Summit III included a conversation about how working well together would ideally look in **ten key areas**:

1. **values**
2. **community education**
3. **administration and policy**
4. **screening and eligibility**
5. **service planning for children and families**
6. **service delivery system development**
7. **funding**
8. **research**
9. **staff skills**
10. **outcome measurement**

### **Action Recommendations**

The action planning recommendations from Summit III are a natural extension of the conversation about working well together and the agreement that these discussions need to be continuous.

**Three recommendations would create structures for continuing the conversation at the state and local levels.** In addition to the system representatives, each structure would include family representation.

***1. Create a statewide children's council***

The statewide council would focus on and ensure state level agency collaboration.

***2. Initiate an ongoing collaboration process among state associations***

The collaboration process among state associations would be a forum for county leaders to work across systems with one another.

***3. Integrate the work of local planning groups***

The local planning groups would be the mechanism for integration within each local area, with significant representation from local agencies.

The further development of and agreement upon common goals would be worked on at all these levels. The **remaining five recommendations** identify specific opportunities for collaborative initiatives as first steps in working well together.

***4. Develop a Proposition 10 implementation initiative***

This initiative would focus on prevention and early intervention, especially for serving children birth to six. Work would include identifying the role of mental health services for this age group and developing statewide skills training, as well as resource development and community education.

**5. Develop a multiple point-of-access screening tool**

This initiative would create a tool for all agencies that can be used by a variety of professionals. If it were used along with cross training and referral practices by many systems, it would ensure “no wrong door” for children and families.

**6. Develop a cross-system approach to outcomes and measurement**

This initiative has, as a long-term goal, the use of a common set of data, outcome, measurement, and evaluation methods. Given the multiple mandates from federal and state government and the information systems that have been created to report on those mandates, this is a daunting task that will begin with small steps and long-term strategy development.

**7. Create a linkage between school health, mental health, and health**

This initiative would focus on the kindergarten through high school population. It would look at how to place mental health services, as a part of school health initiatives, at school sites. Pilots would be developed and evaluated to identify best practices for the future.

**8. Develop a statewide human resource strategic plan**

The ability of any of the service systems to deliver services is built on having a pool of potential employees who have the competencies and skills needed to work in a collaborative environment with children and families having diverse needs. Those working on this long-term initiative will use a wide-ranging set of strategies.

**Next Steps**

Creating the collaborative structures are the highest priority for moving the Summit III ideas forward. Agreement on common goals will occur at the state level, statewide association, and local policy levels.

In addition to talking together about common goals, each of these new structures would have specific projects to work on. One idea is to assign the five collaboration initiatives to these structures for oversight and support:

***Statewide Children's Council:***

- ✓ Develop a multiple point-of-access screening tool
- ✓ Develop a cross-system approach to outcomes and measurement

***State Association Collaborative:***

- ✓ Develop a Proposition 10 implementation initiative
- ✓ Develop a statewide human resource strategic plan

***Local Planning Councils:***

- ✓ Create a linkage between school health, mental health, and health
- ✓ Develop a Proposition 10 implementation initiative (link with state associations)

This assignment of specific projects would also help the state level, statewide association, and local policy structures in developing communication linkages among the structures. As the local level and association initiatives are developed, they are likely to identify state level issues that would be forwarded to the Statewide Children's Council to address and resolve.

The full report of Summit III and the workplan follow.

## WORKPLAN SUMMARY

### Background

Beginning in 1997, on behalf of the California State Department of Mental Health (DMH) and the California Mental Health Directors Association (CMHDA), the California Institute for Mental Health (CIMH) has convened a yearly Children’s Policy Summit.

On behalf of DMH and CMHDA, Summit III was again convened by CIMH on May 24<sup>th</sup> and 25<sup>th</sup>, 1999. These groups, in turn, identified a number of individuals and child and family serving system partners also working to address the needs of California children and families. Summit III was planned as an opportunity for exploration, dialogue, development of shared vision, and adoption of an action plan for mental health in partnership with families and other entities at the state and county level.

### Children’s Summit III Action Recommendations

1. *Create a statewide children’s council*
2. *Initiate an ongoing collaboration process among state associations*
3. *Integrate the work of local planning groups*
4. *Develop a Proposition 10 implementation initiative*
5. *Develop a multiple point-of-access screening tool*
6. *Develop a cross-system approach to outcomes and measurement*
7. *Create a linkage between school health, mental health, and health*
8. *Develop a statewide human resource strategic plan*

These action recommendations can be classified into two groups, structural recommendations and program planning recommendations. The structural recommendations develop the means to carry out program planning recommendations. The program planning recommendations provide specific areas that the structural recommendations for state and local collaboration forums use as areas of focus. These recommendations might fit together as follows:

	<b>Statewide Children’s Council</b>	<b>State Association Collaborative</b>	<b>Local Policy Planning Councils</b>
<b>Proposition 10 Initiative</b>		<b>X</b>	<b>X</b>
<b>Single Screening Tool</b>	<b>X</b>		
<b>Cross System Outcomes</b>	<b>X</b>		
<b>School Health Linkage</b>			<b>X</b>
<b>Human Resources Plan</b>		<b>X</b>	

## WORKPLAN

### **Background**

Beginning in 1997, on behalf of the California State Department of Mental Health (DMH) and the California Mental Health Directors Association (CMHDA), the California Institute for Mental Health (CIMH) has convened a yearly Children's Policy Summit. The Summits identified emerging issues and policy concerns in the provision of mental health services to California children. Each Summit made recommendations to address the identified issues. These recommendations formed the basis for state and county policy and programmatic work over the last several years.

On behalf of DMH and CMHDA, Summit III was again convened by CIMH on May 24<sup>th</sup> and 25<sup>th</sup>, 1999. These groups, in turn, identified a number of individuals and child and family serving system partners also working to address the needs of California children and families. Summit III was planned as an opportunity for exploration, dialogue, development of shared vision, and adoption of an action plan for mental health in partnership with families and other entities at the state and county level. **The goals for Summit III were to:**

- Develop priorities for state and county mental health policy makers in the area of children's services that will offer direction in policy decisions and allocation of resources in the next year, and
- Initiate joint tasks/projects/follow-up for mental health and other child serving agencies in the next year.

Attendee representation included: families, education, early childhood, child welfare, juvenile justice, health, public health, alcohol and other drug services and mental health. There were senior-level state officials as well as leaders from large and small counties throughout California. (A roster of attendees is appended to this summary report.) They worked in small group and large group sessions to identify the issues to be addressed, prioritized action recommendations, and then developed action steps for the eight recommendations identified. Their work in issue identification was converted into a first draft vision of a successfully performing system. This summary of Summit III includes the Action Recommendations and the Draft Vision (a copy of the detailed action steps can be obtained from CIMH).

## **Children's Summit III Action Recommendations**

### **1. Create a statewide children's council (structural recommendation)**

#### ***Long Term Goals***

- Focus on and ensure state-level agency collaboration.
- Establish a common vision, and develop policies and strategies, using research, best practices, outcomes, training and collaboration.
  - ✓ Use incentives to shape local adaptation.
  - ✓ Establish a common data set and local accountability for child and family services.
- Membership might include:
  - ✓ Secretary, Health and Human Services, and executive staff
  - ✓ Chair, Board of Corrections
  - ✓ State Superintendent of Public Instruction
  - ✓ Governor's Education Czar
  - ✓ County Supervisors' Association of California
  - ✓ Family representatives
  - ✓ Judicial Council
  - ✓ Secretary, Youth, Adult and Correctional Agency
  - ✓ Chief Probation Officer representative
  - ✓ Attorney General
  - ✓ Juvenile Justice Commissioners

### **2. Initiate an ongoing collaboration process among state associations (structural recommendation)**

#### **Long Term Goals**

- Develop a shared vision and operationalize it through:
  - ✓ Joint cross-training, education, and technical assistance
  - ✓ Joint conferencing and scheduling at committee level
  - ✓ Blending outcomes, funding, and target populations
- Identify key issues, establish integration across committees and begin regular cross-agency membership/attendance at state level.
- Membership might include:
  - ✓ Chief Probation Officers of California
  - ✓ California Conference of Local Health Officers
  - ✓ County Health Executives Association of California
  - ✓ County Alcohol and Drug Program Administrators Association of California
  - ✓ County Mental Health Directors Association
  - ✓ Child Welfare Directors Association
  - ✓ SELPA Directors Association
  - ✓ Families and youth

**3. Integrate the work of local planning groups (structural recommendation)****Long Term Goals**

- Use Policy Planning Councils as the mechanism for integration at the local level.
  - ✓ Ensure interagency membership and youth and family partners
  - ✓ Create interface for Proposition 10 planning
- Membership might include:
  - ✓ Juvenile Court
  - ✓ Delinquency Prevention Committee
  - ✓ Child Abuse Council
  - ✓ Alcohol and Other Drug Services Advisory Board
  - ✓ Child Care Planning Council
  - ✓ Children and Families First/Proposition 10
  - ✓ County Probation
  - ✓ Community
  - ✓ Youth consumers/families
  - ✓ Major child-serving agencies
  - ✓ Education
  - ✓ Regional centers
  - ✓ Geographic interests
  - ✓ Ethnic interests
  - ✓ Primary care providers and hospitals
  - ✓ Public health
  - ✓ Child care providers
  - ✓ Law enforcement

**4. Develop a Proposition 10 implementation initiative (program planning recommendation)****Long Term Goals**

- Use the major opportunity of Proposition 10 to focus on prevention and early intervention.
- Support a major paradigm shift for the mental health system from a focus on historic target populations.
- Build a shared vision of the service system for 0-6.
- Initiate statewide training on early childhood (include research, best practices, policy models).
- Plan together for resource development and community education.

**5. *Develop a multiple point-of-access screening tool (program planning recommendation)***

**Long Term Goals**

- Support a variety of child/youth referrals (with a variety of levels of need) by various systems.
- Ensure “no-wrong-door” through cross-training and referral practices.
- Create one tool for all agencies that can be used by a variety of professionals.
- Sanction the tool via state and various associations.

**6. *Develop a cross-system approach to outcomes and measurement (program planning recommendation)***

**Long Term Goals**

- Develop a common set of outcomes.
- Develop common measures of indicators.
- Develop an evaluation methodology.
- Define common data set to be collected.
- Address issues regarding various databases.
- Determine analysis plan and use of data as part of planning.

**7. *Create a linkage between school health, mental health, and health (program planning recommendation)***

**Long Term Goals**

- Link children to mental health services at school sites.
- Target the K-12 population (0-6 optional).

**8. *Develop a statewide human resource strategic plan (program planning recommendation)***

**Long Term Goals**

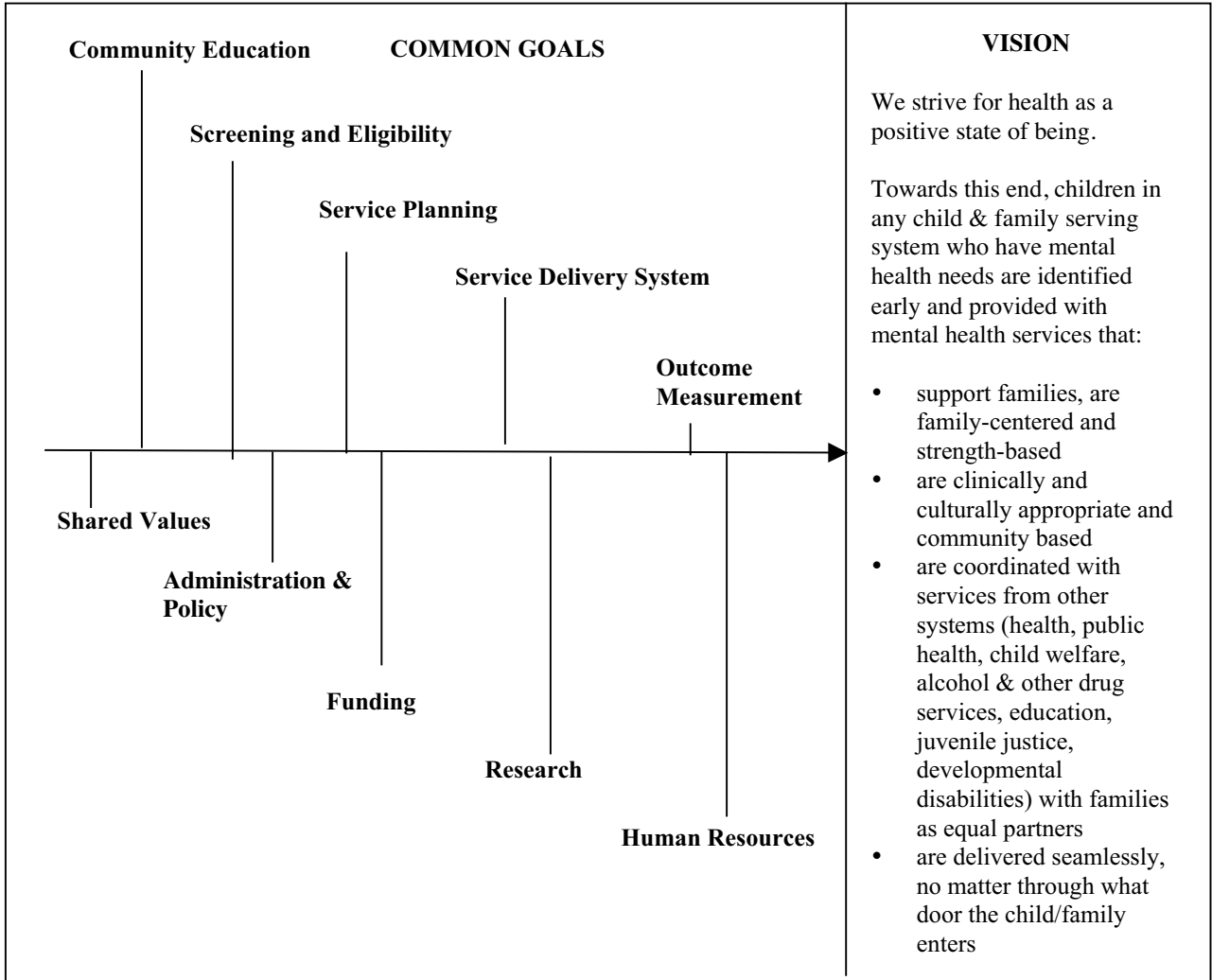
- Address recruitment and retention issues (shortage of social workers and other professional staff).
- Address competencies of current work force and graduates from universities (cultural competence, practice skills, child and family serving system philosophy, teamwork, cross-agency knowledge, best practices).
- Develop a cross-agency curriculum and training process for pre-service and continuing education (include regional centers, technical assistance providers, training academies).

These action recommendations can be classified into two groups, structural recommendations and program planning recommendations. The structural recommendations develop the means to carry out program planning recommendations. The program planning recommendations provide specific areas that the structural recommendations for state and local collaboration forums as areas of focus. These recommendations might fit together as follows:

	<b>Statewide Children's Council</b>	<b>State Association Collaborative</b>	<b>Local Policy Planning Councils</b>
<b>Proposition 10 Initiative</b>		<b>X</b>	<b>X</b>
<b>Single Screening Tool</b>	<b>X</b>		
<b>Cross System Outcomes</b>	<b>X</b>		
<b>School Health Linkage</b>			<b>X</b>
<b>Human Resources Plan</b>		<b>X</b>	

**Common Goals**

A theme that runs throughout the Action Recommendations is the idea of shared vision or common goals: why are we doing this work and what are we trying to create? Families and children are well served when all systems work together with them to achieve the desired result. This section on common goals describes how working well together would ideally look.



**Common Goals: Shared Values**

1. Child and family serving system values are shared by all systems:
  - ✓ Child-centered and family-focused
  - ✓ Individualized services
  - ✓ Comprehensive array of services and supports
  - ✓ Supportive services
  - ✓ Services provided in natural environment
  - ✓ Services provided in least restrictive environment
  - ✓ Services and staff are culturally proficient

2. There is a shared commitment to creating a single collaborative approach to serving children and families and what it means to implement the shared values.
3. There is an explicit value that supports primary prevention.
4. All providers within the child and family serving system have converted from a negative/deficit model to an asset/strength-based, holistic model of planning and delivering service.
5. All systems believe that families are the best places for children to live whenever possible.
6. All systems are culturally competent, with resources that reflect the cultural make up and needs within communities.
7. Public policy is driven by shared values (e.g., prevention as related to welfare reform or violence prevention).
8. Shared values are understood at **all** levels of **all** systems (state/local leadership, direct service providers).
9. All providers within the child and family serving system are educated about the shared set of values.
10. Values that are specific to certain systems are articulated clearly and the need for balance is understood (e.g., child safety, family safety, community safety, learning for other children, voluntary vs. mandatory entry into services).
11. All providers within the child and family serving system are educated in the perspectives of partner agencies and mutual respect is developed for between agencies.

### **Common Goals: Administration/Policy**

1. There is a single state-level cross-system collaboration to establish common vision and provide leadership and ensure impetus, incentives, strategic planning and barrier reduction for local efforts.
2. Leadership collaboration includes the judiciary and engages them in supporting probation as a partner.
3. There are forums for statewide dialogue/problem-solving/consistency within and among each agency within the child and family serving system, as well as local forums (e.g., CPOs need a statewide structure to address broad differences in philosophy and to develop statewide approaches/advocacy).
4. There is a working understanding among the partner agencies in the child and family serving system regarding an integrated model for planning and delivering services that are culturally competent, and all have agreed to move forward to make it happen.
5. Turf issues among the partner agencies are identified and addressed via the collaboration mechanisms.
6. The multiplicity of local "collaboratives" has been folded into a simple, flexible collaborative, responsive to local needs.

7. Families are represented in every step of the process, including the policy-setting process within the child and family serving system.
8. There is support for cross-system prevention services.
9. There is a single method of record keeping and documentation for all agencies.
10. Confidentiality issues have been resolved in a way that supports collaborative service planning while protecting families from inappropriate access to and use of the information that has been collected.
11. There is a single set of standards and a process for credentialing programs and providers.
12. There are statewide and local plans in place to address the human resource issues of recruitment/retention, competencies and training.
13. The state provides leadership in raising and solving Federal categorical issues.

### **Common Goals: Funding**

1. Services that are deemed necessary based on service planning are provided, without the family having to negotiate among agencies/payors.
2. There is a single funding source for the development of local, collaborative, multi-agency infrastructure development (planning, needs assessment, data integration, outcomes development).
3. There are financial incentives for early intervention for mental health, public health, and alcohol and other drug services.
4. Federal financial participation is available for services provided in custody settings/locked facilities.
5. Funding is identified to provide appropriate non-specialty mental health services for those that are non-MediCal-eligible.
6. Funding is identified to provide service to adults attached to MediCal-eligible children.
7. Funding supports an appropriate array of services within a geographic service area.
8. Waivers of all categorical funding are pursued to support flexible, comprehensive services. The agency has moved from pilots to consistent, ongoing policy direction that is statewide.
9. All providers in the child and family serving system understand the concept of blended funding.
10. All providers in the child and family serving system have methods to purchase services from one another.

### **Common Goals: Screening and Eligibility**

1. Prevention is targeted, with identification earlier in the cycle of risk and access to services.
2. Diagnosis is not used to exclude children from access to some level of early intervention services.

3. Access to services is broad, with services provided using methods such as home visiting for newborns, with health and public health taking the lead with the 0-6 population.
4. Family voice, perspective, support and education is present in screening and at every subsequent phase of service delivery.
5. Access to screening is easy for families, with many doors.
6. The focus of screening activities, and the key systems involved in screening changes over the developmental process.
7. Consultation/training is provided to primary care providers, child care providers, families, and in community settings as a method of early screening (including prenatal, NICU, and DDS).
8. There are cross-system, best-practice, age-appropriate, culturally-competent, multi-component screening, assessment and placement tools that provide a common taxonomy.
9. Every screening is an intervention, something is done for every referral, and screenings are not used for "profiling."
10. There is earlier and more appropriate screening for mental health and alcohol and other drug services issues, resulting in earlier intervention.
11. There is a continuum of eligibility, with different rules and services for prevention than ongoing services. The rules increase with more intense levels of treatment (funnel model).
12. Mental health and alcohol and other drug services providers are able to assess for both sets of issues and refer to one-another appropriately.
13. Multidisciplinary assessment occurs in all custody settings.
14. Sibling screening is provided in families with children already involved in one or more systems.
15. There is screening for all those in the foster care system, including those placed through probation, with relatives, and at home.
16. The child and family serving system target population includes all children who have mental health issues who are poor or in another public system.
17. Children who have no coverage, especially 0-6, have a minimum basic right to screening, assessment and referral.
18. The financial and medical necessity requirements for eligibility are simplified and easy to understand.
19. The integration with private insurance assures families of access to an appropriate array of services.
20. It isn't necessary for families to use any other service (e.g., juvenile justice, education) to gain access to mental health services.

### **Common Goals: Service Planning**

1. There is an inventory of cross-agency services and programs, to support collaborative planning.
2. There is one case plan for one family, for comprehensive, culturally-competent services from all appropriate systems.

3. Assessment means “sitting alongside,” working with parents in partnership.
4. Service planning includes regular reassessment to guide service plan changes to meet needs, with parents feeling they are driving the system and not that they or the child have been taken over by the system.
5. The child is seen in the context of the family and families are included as equal partners in assessment, planning and goal-setting.
6. Service planning links together providers from physical health, special education, alcohol and other drug services, public health and mental health.
7. Out-of-state and out-of-county placements have common criteria, authorization for mental health treatment, rates, credentialing and documentation procedures.

### **Common Goals: Service Delivery System**

1. There are sufficient services for all age groups within the child/youth developmental framework (0 - early 20s).
2. There is a full array of services within or available to geographic service areas, from prevention to alternative treatments, (respite, aides) to treatment, to very intensive services.
3. There are early (first weeks of life) opportunities for parent support linked to well-baby settings.
4. Settings such as communities, physician's offices, and child care providers are non-stigmatizing sites for parent training and early services for small problems.
5. Community settings are available to serve low-risk children, and the service system builds on existing community resources.
6. There is adequate access to physical health care for children and youth, especially those in foster care.
7. There are alcohol and other drug service models targeted to adolescents.
8. There are mental health services in alcohol and other drug services, and alcohol and other drug services in mental health services, and integrated dual diagnosis services for all youth and adults with intense needs.
9. Services (mental health, alcohol and other drugs) are provided within juvenile justice custody settings.
10. Adults attached to eligible children are provided with mental health/alcohol and other drug services treatment as needed, separate from family treatment.
11. Services provided address the multiple needs of the family.
12. Every agency within the service system brings unique areas of expertise into the collaborative development of a service system (e.g., public health with epidemiology and prevention/early intervention).
13. Comprehensive models of service delivery that ensure quality and appropriate expertise free up staff from multiple systems all interacting with the same family.

14. Family members are used as providers of services.
15. There is shared accountability (mental health, child welfare, probation, education) for out-of-state, SED/IEP placements.
16. Rehabilitation models that work are in use in all agencies within the child and family serving system.
17. Service delivery models are culturally competent.
18. Service delivery models are results-based, continuously evaluated and improved to achieve outcomes.

### **Common Goals: Outcome Measurement**

1. All systems are accountable to a core set of outcomes and measures.
2. There is an integrated, cross-system database that is accessible to all disciplines and is based on common data definitions.
3. One agency collects basic information once, on a multi-agency instrument, and information is shared so that families do not have to repeat the information/assessment process.
4. Communities are involved in identifying the outcomes that are needed.

### **Common Goals: Research**

1. Research provides best practice models for training providers in the most effective techniques.
2. Research/child development knowledge is used to set policy, establish program initiatives, and reorganize resources.

### **Common Goals: Community Education**

1. There is community-wide training regarding developmental, early childhood issues, with wide public awareness.
2. The community-wide training supports non-stigmatized early identification that is pre-risk.
3. Training provides a shared understanding of what is a mental health problem, and addresses potential denial.

### **Common Goals: Human Resources**

1. All providers in the child and family serving system are provided training in cross-discipline, cross-agency screening, assessment and referral.
2. All providers reflect the ethnic make up of the community, and all providers are trained in culturally competent service delivery.
3. All providers in the child and family serving system understand the different cultures of the various agencies, and have a common language for communication.
4. There are sufficient numbers of appropriate providers to meet the service needs in a geographic area/school district.

5. Providers are skilled in the most effective therapeutic techniques.
6. Bargaining units are educated about and supportive of collaboration and integration of service delivery.

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