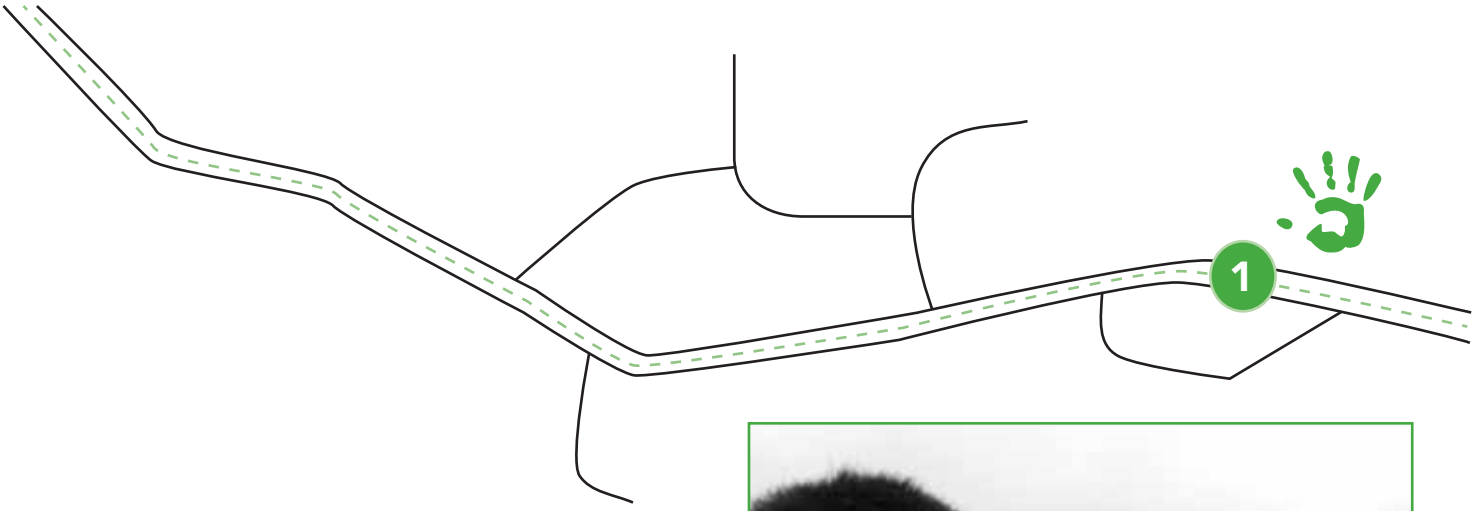
Bring the Kids Home

BTKH Update and 2 Year Plan

State of Alaska • Department of Health & Social Services • Fiscal Years 2012–13

More information can be found on our website: ***http://www.hss.state.ak.us/commissioner/btkh/***



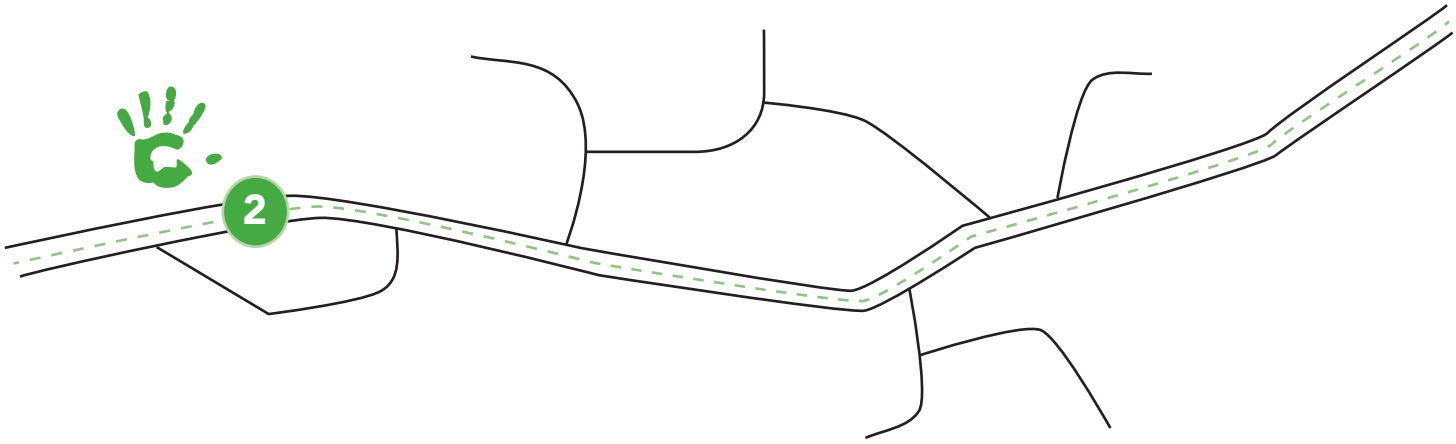
This document provides a road map of **Bring the Kids Home (BTKH):** where it started, progress, goals, and plans for the final two years. The online version provides access to additional material, including reports, graphs and video clips.

Online version:

http://hss.state.ak.us/commissioner/btkh/pdf/2yearplan2012-13

Note:

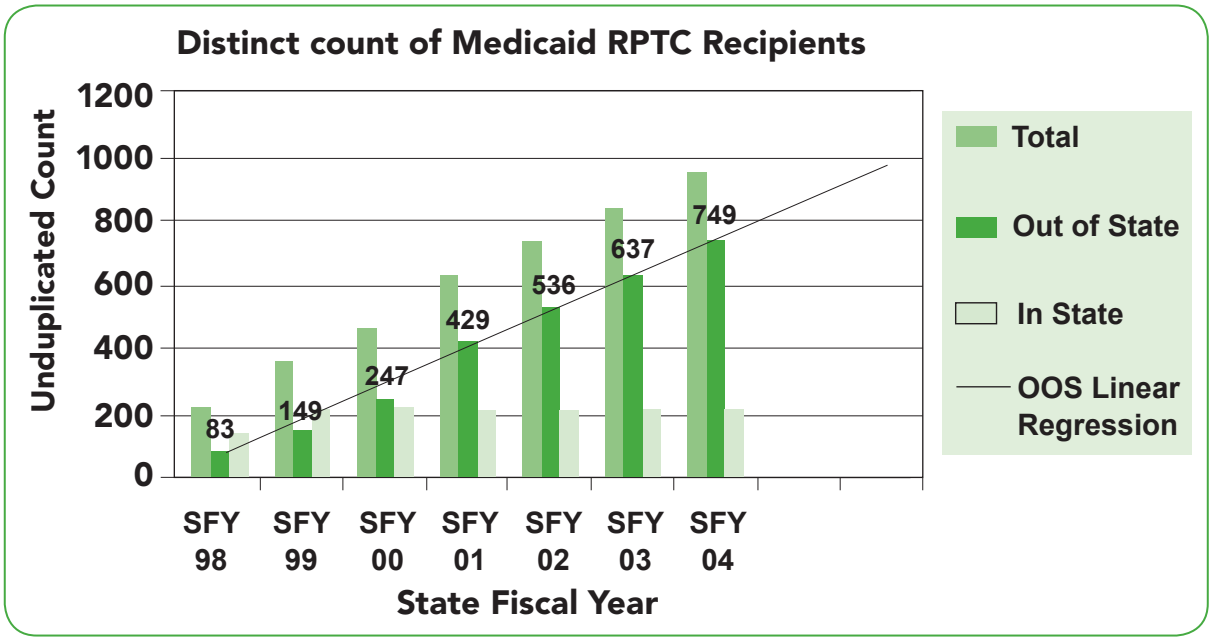
Accessible links are in green bold italic throughout the online version.



History:

Bring the Kids Home (BTKH) is an initiative to reduce the number of Alaska children with severe emotional disturbances who are served in out-of-state residential psychiatric treatment facilities, and to improve outcomes for Alaska children with behavioral health problems.

From 1998 to 2004, Alaska's behavioral health system became increasingly reliant on Residential Psychiatric Treatment Centers (RPTC) for treatment of severely emotionally disturbed youth. Out-of-state placements in RPTC grew by nearly 800 percent.



As a result, Medicaid expenditures for out-of-state RPTC experienced an increase of over 1,300 percent (to over $40 million) and were projected to continue increasing. Children were placed outside of Alaska for long periods — even years — for treatment. Families making these difficult choices often found that out-of-state placement created unanticipated problems. It was difficult for families to participate in their child's treatment, transitions back to home were challenging, and Alaska Native children sometimes experienced a cultural loss because their experiences diverged widely from those of their families.

**Data for this report were provided by the Division of Behavioral Health, Policy and Planning*

"I just feel like with every resource that we have available to us, why don't we have this here? Why?" "How do we raise our children and teach them the values and the love that we want them to grow up with if they're in an institution?"

***Parent quotes** from Channel 11 **"Breaking the Cycle"** on BTKH 2009*

These issues drove the Alaska Mental Health Trust Authority and the Department of Health and Social Services (DHSS) to establish and jointly chair the Bring the Kids Home Focus Group. Cross-system collaboration is a key BTKH strategy. Family and youth advocates, tribes, schools, providers and community stakeholders participate in the BTKH Focus Group. The Alaska Planning Boards (Alaska Mental Health Board, The Advisory Board on Alcoholism and Drug Abuse, The Governor's Council on Disabilities and Special Education, and the Traumatic Brain Injury Board) are key Focus Group members, bringing statewide stakeholder feedback. Tribal health organizations, the Denali Commission, the Department of Education, the University of Alaska and school districts all partner with DHSS and the Trust on BTKH. Most of those involved in the BTKH Focus Group also participate in project-specific work groups. The Trust, DHSS, the Alaska Legislature and the Governor allocate the essential resources required to address these problems.

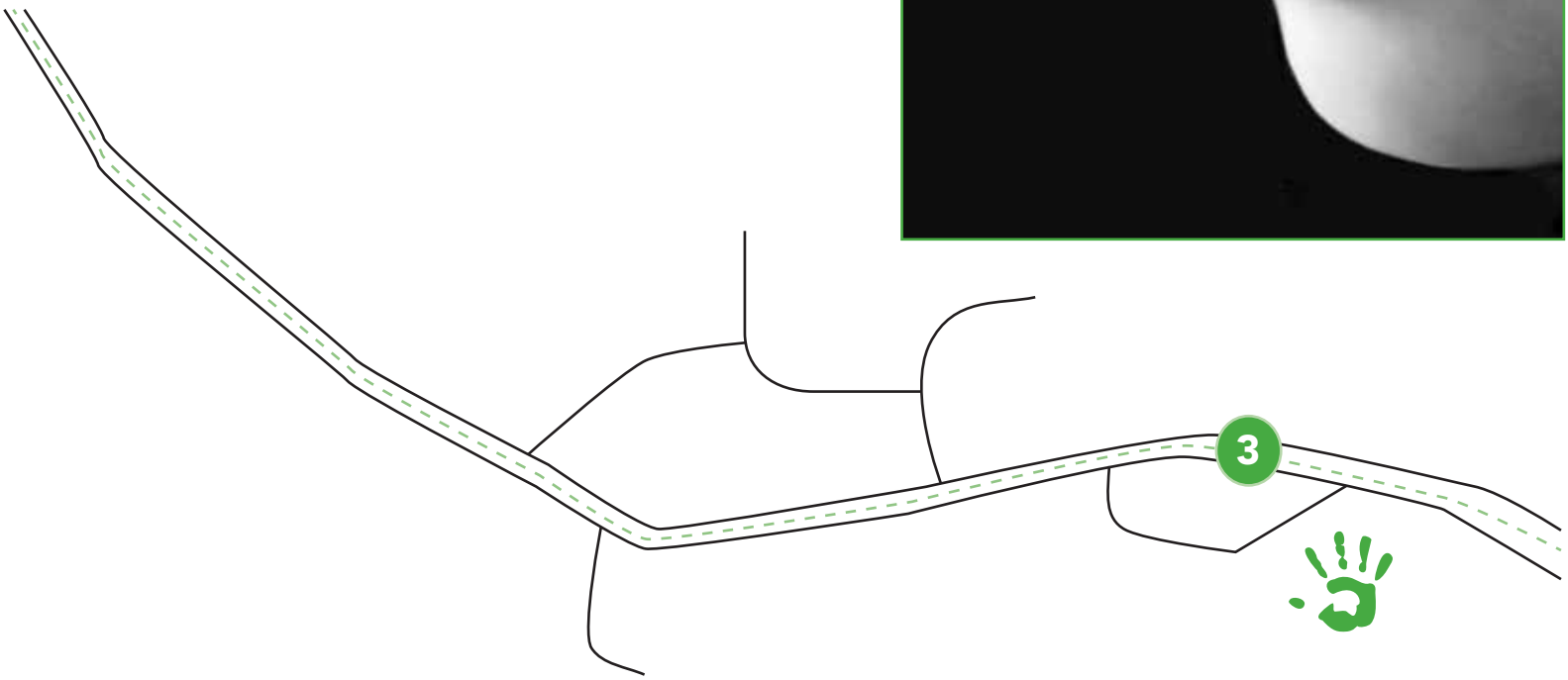
Stakeholders developed BTKH guiding principles for system development:

- Kids belong in their homes (least restrictive, most appropriate setting, community-based).
- Strengthen families first (strength-based, preventative)
- Families and youth are equal partners (family-driven, youth-driven).
- Respect individual, family and community values (culturally competent, individualized care, community-specific solutions).
- Normalize the situation (meet the child where he or she is, respect normal life cycles, promote normal and healthy development).
- Help is accessible (coordinated and collaborative).
- Consumers are satisfied and collaborative, meaningful outcomes are achieved (emphasis on research, evidence, quality improvement, accountability).

Progress and Goals:

BTKH resources were used to address funding and service gaps; parent supports, outpatient services, and treatment beds were established. Use of best practices was expanded, including ***Multidimensional Treatment Foster Care***, ***Parent Child Interaction Therapy***, *the* ***Teaching Family Model***, ***Early Childhood Mental Health Consultation***, ***Positive Behavioral Supports***, *the* ***Transition to Independence Process***, ***Parenting with Love and Limits*** and several others. Rate increases supported capacity expansion, and a flexible funding pool was created to divert children from residential care.

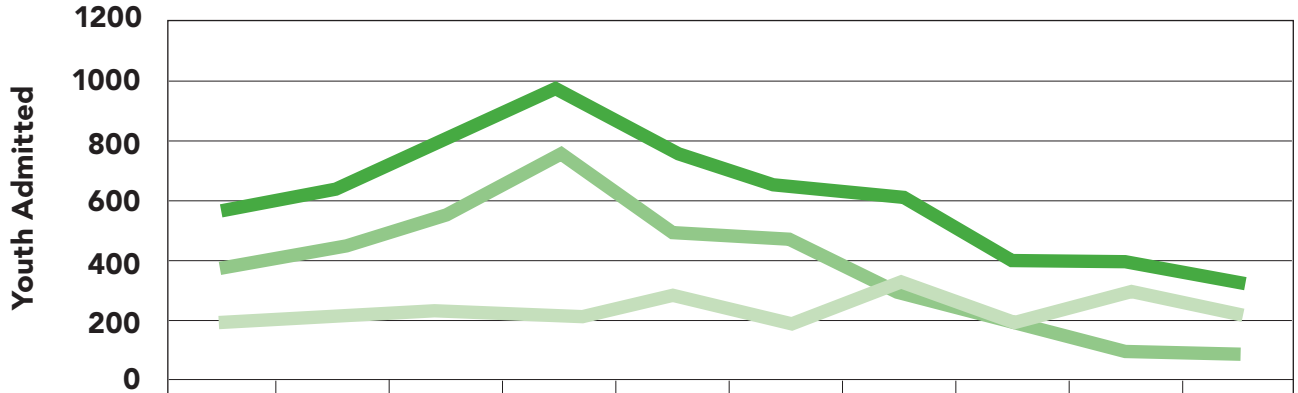
Increased oversight, care coordination and support by state staff, contractors and grantees ensures full utilization of in-state resources. New state staff identify youth who have not accessed in-state services and link them to in-state care — thus avoiding lengthy outside placements. Requirements for family involvement and transition planning for children in RPTC were increased. Policy changes tightened criteria for acute and residential care. Regulation changes are underway to expand access to mental health services for young children. Data indicators were established to evaluate progress, identify trends and target resources.



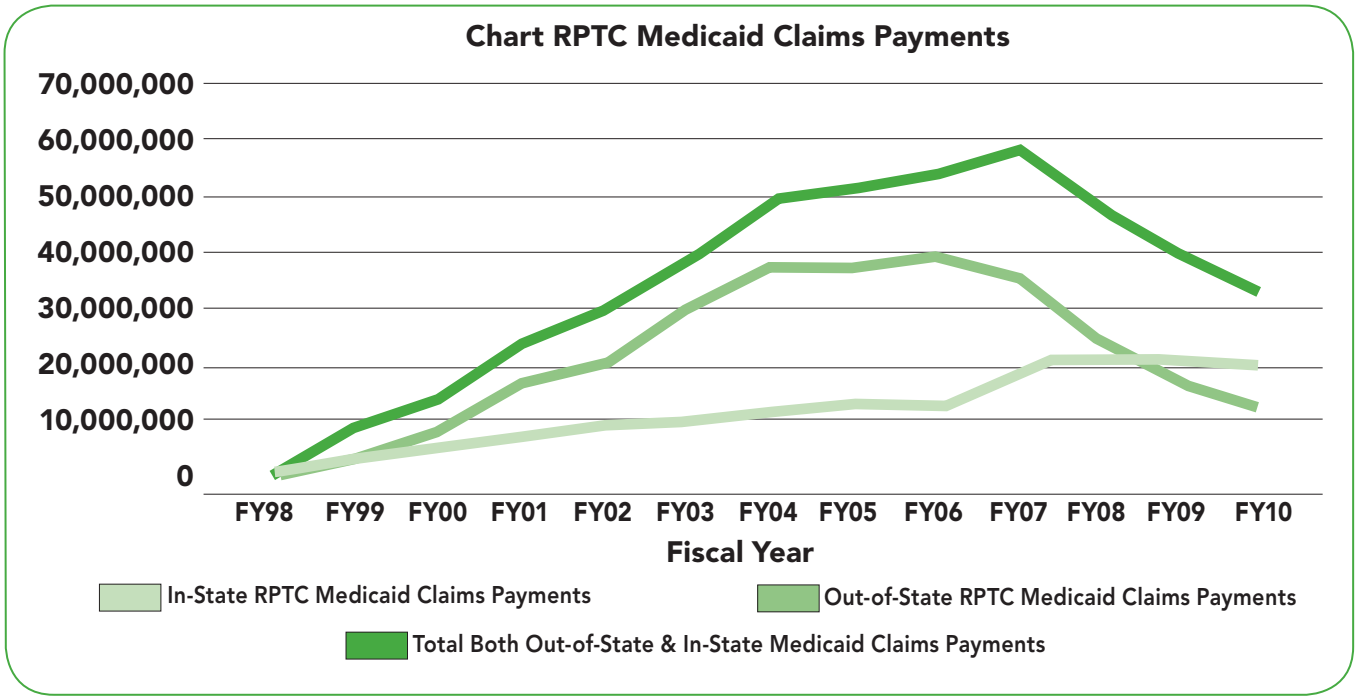
As a result of planning, capacity development, management and policy shifts, and the investment of new resources, BTKH has been extremely successful:

- Total yearly admissions to out-of-state RPTC decreased by 88.1 percent between fiscal year 2004 and fiscal year 2010.
- Recidivism to RPTC decreased from 20 percent to 8.6 percent between fiscal year 2004 and 2010.
- Expenditures for out-of-state RPTC decreased from over $40 million to $15.2 million between fiscal year 2006 and fiscal year 2010.

Unduplicated Count Medicaid RPTC Recipients "Admitted"



	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10
In-State	192	203	226	213	274	191	323	211	289	205
Out-of-State	381	437	552	752	489	473	297	202	110	90
Total	573	640	778	965	763	664	620	413	399	295



For more information on the charts - FY10 DATA REPORT

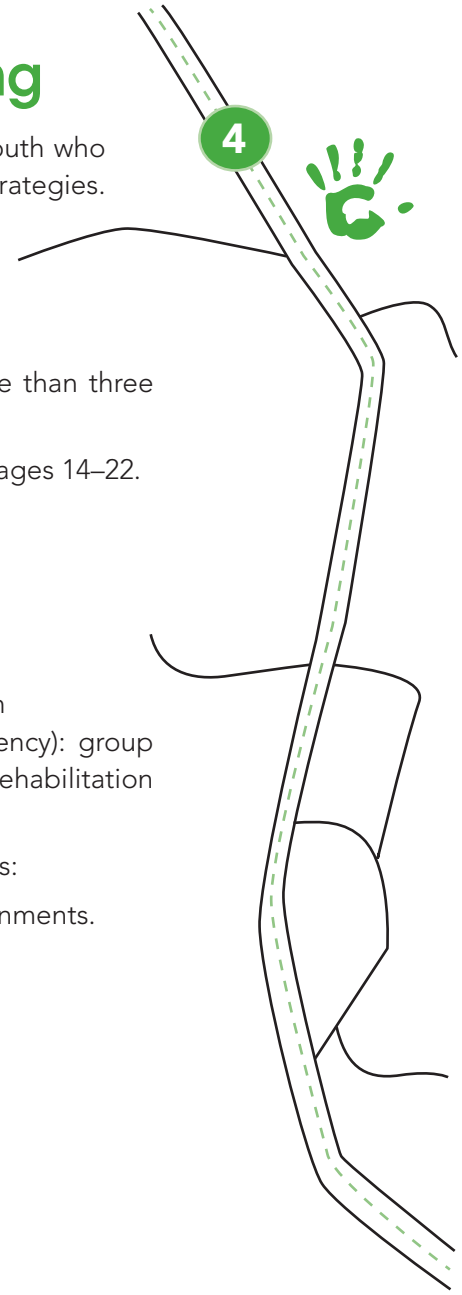
BTKH weekly Count

Defining BTKH "Success"

By fiscal year 2013, DHSS and The Trust intend to "end" BTKH successfully. Success has been defined as fewer than 50 new admissions to out-of-state RPTC per year, and fewer than 100 total recipients. For fiscal year 2010 there were 90 new admissions to out-of-state RPTC and 221 total recipients. (Yearly admissions include only youth admitted to a RPTC during the fiscal year. Recipients include any youth served during the fiscal year, even those admitted during a previous fiscal year.)

Data to Guide FY12 and FY13 Planning

The Division of Behavioral Health is monitoring the characteristics of those youth who continue to move into out-of-state RPTC. This data guides BTKH planning and strategies.



Referral Patterns for Alaska Youth in out-of-state RPTC:

1. 78 percent of youth are referred by acute care settings.
2. 56 percent had a primary referral reason of aggression. This was more than three times higher than any other reason.
3. Most are admitted (64 percent) and discharged (88.1 percent) between ages 14–22.
4. 25 percent of discharges were young adults 18–21.
5. Most youth are from Anchorage (51 percent) {Northern (19.2 percent), Mat-Su (11.6 percent), Southwest (7.1 percent), Southeast (6.6 percent)}.

Personal Characteristics of Alaska Youth in out-of-state RPTC

6. 66 percent went to their parent or another relative upon discharge from out-of-state RPTC. The rest of the youth went to (in order of frequency): group homes; therapeutic foster homes, independent living, a behavioral rehabilitation facility, a guardian, a foster home or the military.
7. Most come from families with significant challenges and multiple needs:
    - Nearly all report problems with support groups and social environments.
    - 70 percent have a family history of substance abuse.
    - 64 percent have a family history of mental illness.
8. Most youth have been traumatized:
    - 76 percent have experienced multiple traumas.
    - 64 percent have experienced physical abuse.
9. 62 percent are diagnosed with mood disorders.
10. 34 percent are Alaska Native.

Co-Morbidity Patterns for Alaska Youth in out-of-state RPTC

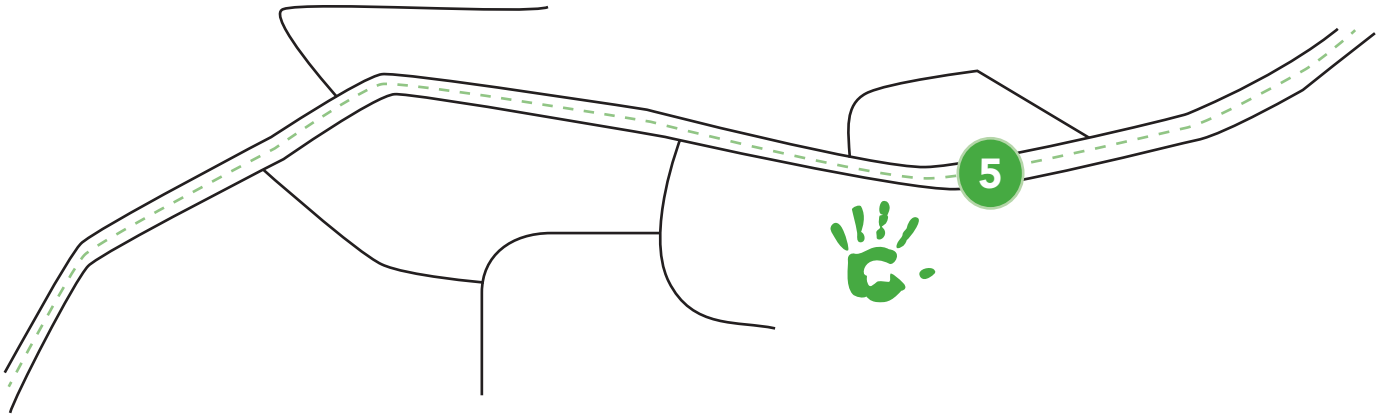
11. 60 percent have one or more co-morbidity, for example, a health condition, or a fetal alcohol spectrum disorder.

Educational Issues for Alaska Youth in out-of-state RPTC

12. Most youth admitted to an out-of-state RPTC have education issues:
    - 84 percent had "education" as a psycho-social factor.
    - 56 percent had "school suspension" as a risk factor.
    - 41 percent had an individualized education plan.

Data are from the Division of Behavioral Health, Policy and Planning.
For more information click on these links:

- ***RPTC Admissions Summary***
- ***RPTC Discharges Summary***



Six Strategies

Six strategies underlie BTKH progress and are the foundation for fiscal year 2012 and fiscal year 2013 projects. An outline of the anticipated budget increments related to these six strategies is provided below.

Budget parameters:

- The BTKH budget is based on the work of the BTKH stakeholders, with input from The Trust, DHSS and the Alaska Planning Boards.
- The projects are designed to reduce utilization of more expensive and restrictive levels of care.
- It expands effective BTKH strategies to new communities, or to additional providers.
- It requests investment of general funding only when required to sustain strategies piloted and found to be effective through Mental Health Trust Authority Authorized Receipts (MHTAAR) funding.
- The fiscal year 2013 budget is an estimate. It will be refined based on:
    - The outcomes of ongoing efforts.
    - Budget increments received for FY12.
    - Ongoing data and outcomes.

FY12 and FY13 funding shown in thousands of dollars.

BTKH FY12 and FY13 Proposed Budget Increment Summary

This summary reflects the budget increments proposed by the BTKH stakeholder group. It does not reflect the final budget increments requested by the Department of Health and Social Services. ***Budget Increment Brief Descriptions***

Strategy One — **Capacity Enhancement**

	FY12				FY13			
	MHTAAR	GF/MH	Other	Total	MHTAAR	GF/MH	Other	Total
Total:	$525.0	$1,405.0	$0.0	$1,930.0	$575.0	$2,625.0	$2,000.0	$5,200.0

Strategy Two — **Care Coordination**

	FY12				FY13			
	MHTAAR	GF/MH	Other	Total	MHTAAR	GF/MH	Other	Total
Total:	$100.0	$350.0	$250.0	$700.0	$100.0	$100.0	$0.0	$200.0

Strategy Three — **Funding Gaps**

	FY12				FY13			
	MHTAAR	GF/MH	Other	Total	MHTAAR	GF/MH	Other	Total
Total:	$688.0	$463.0	$0.0	$1,151.0	$688.0	$398.0	$0.0	$1,086.0

Strategy Four — **Data, Outcomes and Reporting**

	FY12				FY13			
	MHTAAR	GF/MH	Other	Total	MHTAAR	GF/MH	Other	Total
Total:	$205.0	$0.0	$0.0	$205.0	$100.0	$0.0	$0.0	$100.0

Strategy Five — **Collaboration and Partnerships**

	FY12				FY13			
	MHTAAR	GF/MH	Other	Total	MHTAAR	GF/MH	Other	Total
Total:	$125.0	$150.0	$0.0	$275.0	$150.0	$100.0	$0.0	$250.0

Strategy Six — **Workforce Development**

Workforce Development Funded in WF Development Focus Area or in Other Project Areas

Total FY12 and FY13 BTKH Increments

	FY12				FY13			
	MHTAAR	GF/MH	Other	Total	MHTAAR	GF/MH	Other	Total
GRAND TOTAL:	$1,643.0	$2,618.0	$0.0	$4,261.0	$1,613.0	$3,223.0	$2,000.0	$6,836.0

BTKH strategies with projected projects, activities and increments for the next two years.

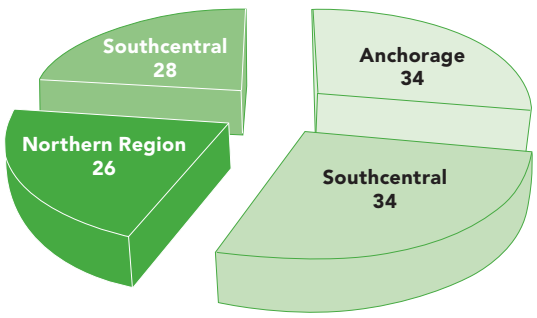
Strategy One — **Capacity Enhancement**

	FY12				FY13			
	MHTAAR	GF/MH	Other	Total	MHTAAR	GF/MH	Other	Total
Total:	$525.0	$1,405.0	$0.0	$1,930.0	$575.0	$2,625.0	$2,000.0	$5,200.0

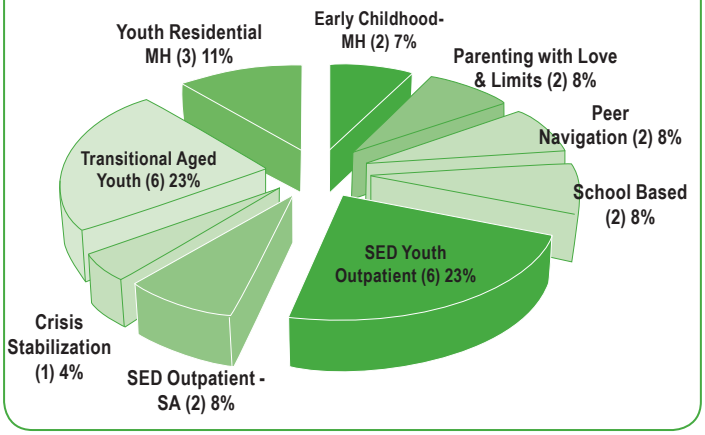
Strategy 1: Building in-state capacity for lower levels of care and for nonresidential care.

Medicaid funding that formerly went to out-of-state RPTC has been invested to expand in-state services and to implement best practices. This represents a substantial investment into community-based services and the in-state work force. The BTKH Home and Community-Based Grant program funded 26 BTKH grants for FY11 alone *(see graphs below)*.

FY06 to FY11 Home and Community-Based Grants by Region



FY11 BTKH Grants Breakdown by Service Type



However, in-state providers continue to have difficulty serving some populations of youth. Over the next two years we will:

a. Address remaining bed capacity needs:

- Request an updated residential rate study, a rate increase, and a long-term cost of living methodology for Behavioral Rehabilitation Services Levels II through V.

Rate Review Update to FY11 Project

- Expand sub-acute stabilization services, (in Fairbanks, Mat-Su and/or Juneau).
- Develop strategies to support high-risk youth of transition age in housing.
- Work with providers to convert some existing beds to serve specialty populations.

b. Address outpatient service gaps:

- Increase delivery of intensive family therapy models such as ***Parenting with Love and Limits***. *(See box on next page)*
- Appropriately treat traumatized children.
- Appropriately treat children birth to 5.
- Effectively treat youth with co-morbidities or extreme presentations.

The following is a real-life example of how BTKH Individualized Service Agreements have impacted the lives of children with severe emotional disturbance. Identifying information has been changed to maintain confidentiality. This information was submitted by a mental health worker involved in the youth's treatment:

This youth was in a group home and admitted to the program after being in an out-of-state residential treatment center with severe episodes of mania and depression, lack of coping skills and poor social skills. During the senior year, it was identified that he was behind in high school credits due to confusion between the residential school setting and transferred credits to the community high school. ISA was used to provide Sylvan tutoring for credit, which this youth accredits to his being able to successfully graduate with his peers. Recently, ISA was used to provide an initial supply of bulk food, housewares, and household cleaning items to support the transition to independent living and reduce additional stressors.

The youth is now 19 years old, maintaining a job, church responsibilities, and obtaining a secondary education in addition to typical errands and chores that go along with independent living. He humbly states that "if it weren't for Sylvan, I don't know what I'd be doing."

Link here for more ISA stories

c. Evaluate individualized service agreements (ISA) and prioritize key uses. *(See box)*
   - Ensure that all providers know how to use ISA.
   - Continue analysis of ISA impact and outcomes.
   - Prioritize access based on data.
   - Manage to ensure sufficient funds throughout the year.

d. Address gaps in school-based behavioral health services:
   - Expand Medicaid billing by schools. ***School Medicaid Toolkit***
   - Expand positive behavioral supports (PBS) and document the outcomes of PBS programs.
   - Support collaboration between schools and community providers.
   - Continue collaboration between the Department of Education and Early Development (DEED) and DHSS.
   - Expand involvement of school districts in system development.

Parenting with Love and Limits® (PLL) is a recognized evidence-based Best Practice treatment model. It is the first program of its kind to combine parenting management groups and family therapy into one continuum of care to quickly engage resistant parents.
Parenting with Love and Limits® (PLL) is recognized as an evidence-based model by these research organizations:

- OJJDP Model Programs Guide - Exemplary Rating
- Promising Practices Network on Children, Families and Communities
- Find Youth Info.gov
- In addition, PLL is listed on NREPP: SAMHSA's National Registry of Evidence-based Programs and Practices

Target Population: Adolescents and Children, aged 10-18, with severe emotional and behavioral problems, alcohol or drug use, truancy issues, domestic violence, suicidal ideation, depression or ADHD.

Strategy Two — **Care Coordination**

	FY12				FY13			
	MHTAAR	GF/MH	Other	Total	MHTAAR	GF/MH	Other	Total
Total:	$100.0	$350.0	$250.0	$700.0	$100.0	$100.0	$0.0	$200.0

Strategy 2: Expand care coordination for children referred to residential treatment.

Before BTKH, children were moving into out-of-state RPTC without accessing all available in-state resources, and were remaining in RPTC for too long. A new DHSS utilization review team now works with state contractors and grantees to ensure that all children first access in-state resources. Changes in policy, practices, contracts and grants also maximize use of in-state resources. Over the next two years we will:

a. Expand care coordination to additional children at risk of/returning from RPTC.

b. Target youth with high-risk families and in acute care for intensive home-based services.

c. Expand peer navigation to additional communities.

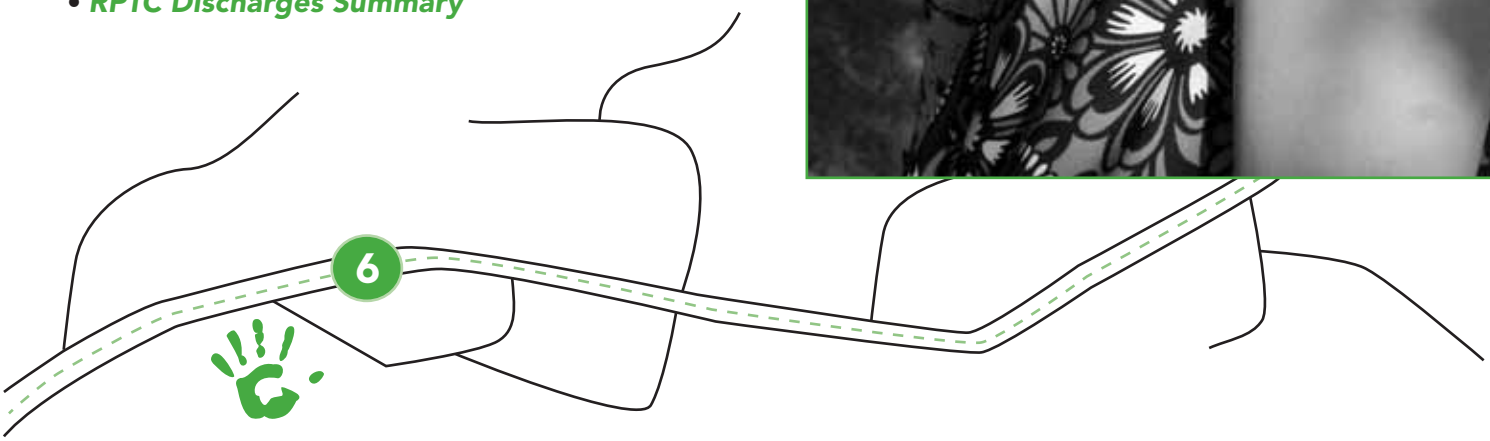
d. Formalize the peer navigation model.

e. Improve educational transitions for children leaving residential care.

f. Refine and institutionalize new policies and practices.

For more information and data go to:

- ***RPTC Admissions Summary***
- ***RPTC Discharges Summary***



Strategy Three — **Funding Gaps**

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	MHTAAR	GF/MH	Other	Total	MHTAAR	GF/MH	Other	Total
Total:	$688.0	$463.0	$0.0	$1,151.0	$688.0	$398.0	$0.0	$1,086.0

Strategy 3: Address systemic funding gaps and seek federal funding for system development.

Systemic gaps in access to services, workforce and implementation of best practices prevent young children and their families from receiving behavioral health services. However, most adolescents currently admitted to out-of-state RPTC have families with a history of substance use or mental health disorders and have experienced trauma. The Adverse Childhood Experiences Study provides an explanation for this by illustrating the negative impacts of early trauma on lifelong health and mental health *(see box, below)*.

In Alaska, approximately 45-50 percent of substantiated victims of child maltreatment are birth through five years of age. Many young children are demonstrating the impact of maltreatment or developmental issues at an early age: the 2004 Alaska Market Rate Survey of child care programs found that 38 percent had asked families to withdraw a child under the age of 6 with social/emotional problems. Bring the Kids Home grants are piloting best practices identified through the ***"Early Childhood Comprehensive Systems"*** planning to address gaps in services for young children.

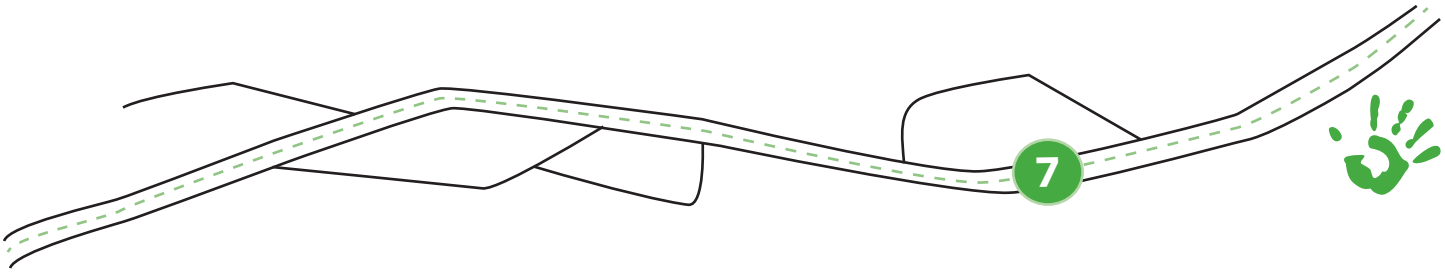
Adverse Childhood Experiences (ACE) Study: Major Findings

Childhood abuse, neglect, and exposure to other traumatic stressors which we term adverse childhood experiences (ACE) are common. Almost two-thirds of study participants reported at least one ACE, and more than one in five reported three or more ACE. The short and long-term outcomes of these childhood exposures include a multitude of health and social problems.

The ACE study uses the ACE Score, which is a count of the total number of ACE respondents reported. The ACE Score is used to assess the total amount of stress during childhood and has demonstrated that as the number of ACE increase, the risk for the following health problems increases in a strong and graded fashion:

- Alcoholism and alcohol abuse
- Illicit drug use
- Early initiation of smoking
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Sexually transmitted diseases (STDs)
- Early initiation of sexual activity
- Adolescent pregnancy Suicide attempts

ACE study website



Youth and young adults with behavioral health challenges also encounter service gaps. Programs in Alaska do not adequately meet the needs of youth transitioning to adult roles. The 2007 Alaska Health Care Data Book reports that young adults 18 to 24 have the most self-reported days of poor mental health and the highest rates of binge and heavy drinking. Youth ages 15 to 24 have suicide rates that are as much as 10 points higher than the next age group. An Institute of Social and Economic Research study of Covenant House youth in crisis placement found that nearly 40 percent had previously been in behavioral health treatment. This problem is not unique to Alaska: national studies have shown youth with behavioral health challenges have poorer outcomes in many areas. Through BTKH, new projects are implementing the ***"Transition to Independence Process"***; an evidence-informed process to improve outcomes for youth transitioning to adulthood.

Covenant House study summary

Full study

Over the next two years, BTKH will address system gaps by:

a. Making regulation, policy and funding changes to reach children and families earlier.

b. Expanding evidence-supported programming for children birth to 5 and their families.

c. Expanding Intensive Family Preservation for children at risk of a protective services placement.

d. Implementing the Transition to Independence Process.

   2009 Youth Summit Report

   Transition Age Youth Charter Document

   National Youth In Care Network

   Transition to Independence Process

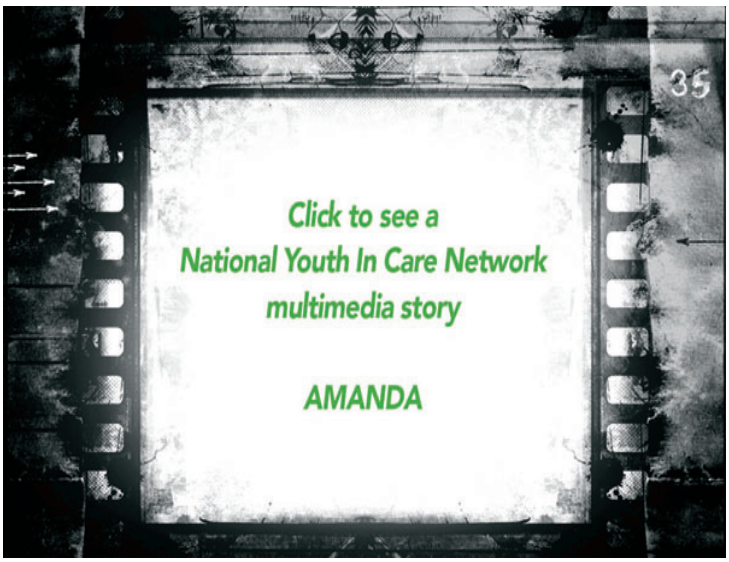
e. Supporting development of the "Seeds of Change" project in Anchorage.

   Alaska Seeds of Change Overview

   This video link describes the ***"Food Project Of Boston"***, which is a social enterprise project and has been highly successful in Massachusetts. "***Seeds of Change***" was in part modeled after the ***"Food Project Of Boston."***

f. Applying for federal grants to leverage system development.

***Note:** State of Alaska security warnings may be in place. To view videos, choose ALLOW , hit OKAY when asked. In yellow menu bar OPTIONS choose TRUST THIS DOCUMENT ONE TIME ONLY and then click on video box.



You may view other stories on YouTube
http://www.youtube.com/watch?v=Pwh4wn00WmQ

Strategy Four — **Data, Outcomes and Reporting**

	FY12				FY13			
	MHTAAR	GF/MH	Other	Total	MHTAAR	GF/MH	Other	Total
Total:	$205.0	$0.0	$0.0	$205.0	$100.0	$0.0	$0.0	$100.0

Strategy 4: Improving reporting mechanisms to monitor system access, outcomes and service utilization.

In preparation for ending BTKH, DHSS will continue to monitor the characteristics and trends of children in RPTC and their families and will set up long-term monitoring. In addition, DHSS will establish structures to maintain system development and collaborative oversight. Over the next two years we will:

a. Implement client satisfaction and functional improvement measures within RPTC.

b. Establish a single site to track availability of all in-state residential behavioral health beds.

c. Clearly define residential levels of care.

d. Implement a decision-support tool for residential placement.

e. Continue evaluation of BTKH projects and use this data to guide system development.

f. Institutionalize long-term indicators to monitor system performance.

g. If possible, include mechanisms to gather data on outcomes 10 years post discharge.

h. Formalize agreements to transition Bring the Kids Home activities into business as usual:

- Continuing ongoing projects
- Cross-system planning and system development
- Managing BTKH resources in DHSS
- Joint oversight of long-term indicators
- Ongoing stakeholder input into behavioral health system development

Strategy Five — **Collaboration and Partnerships**

	FY12				FY13			
	MHTAAR	GF/MH	Other	Total	MHTAAR	GF/MH	Other	Total
Total:	$125.0	$150.0	$0.0	$275.0	$150.0	$100.0	$0.0	$250.0

Strategy 5: Developing partnerships with communities and in-state providers to organize the resources and assistance needed to serve children experiencing severe disturbances and their families.

During fiscal year 2008 and fiscal year 2009, BTKH Planning Summits were held in communities across Alaska. These informed training and technical assistance strategies. BTKH has supported community teams to collaborate to address the needs of youth with challenging presentations. Over the next two years, we will:

a. Continue to address issues from BTKH summits and those voiced by providers and stakeholders

   2008 Summit, summary

   2007 Summit, summary

   2007 Summit

   Anchorage Summit

b. Continue collaboration with tribal behavioral health directors and rural service expansion
c. Support community collaborations to expand school-based behavioral health services
d. Support collaborations to implement the Transition to Independence Process
e. Support development of community BTKH planning teams
f. Increase integration of parents and youth in service planning and in system development and evaluation
g. Improve management of psychiatric medications by primary care doctors by providing psychiatric consultation through Alaska Psychiatric Institute (API)

Strategy Six — **Workforce Development**

Workforce Development Funded in WF Development Focus Area or in Other Project Areas

Strategy 6: Implementing strategies to develop and maintain a skilled in-state work force.

A new focus area has been established with primary responsibility for statewide health and behavioral health work force development. The majority of BTKH workforce development will be through the work of this group. However, over the next two years we will continue strategies to expand expertise in specific areas related to BTKH through technical assistance, training, startup grants and contracts.

Workforce Development Focus Area

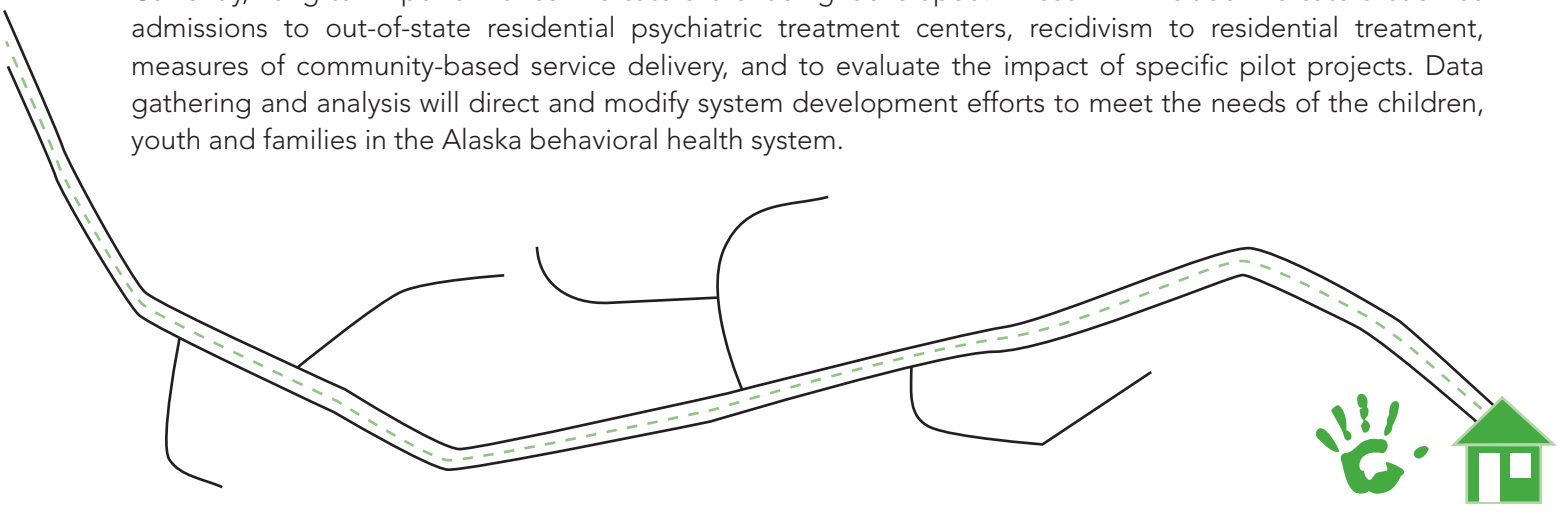
Ending Bring the Kids Home

During the remainder of fiscal year 11 and fiscal years 12 and 13, we will transition BTKH projects into business as usual and BTKH will end as an initiative. This means that enough resources have been dedicated to the BTKH effort to develop/maintain a basic in-state continuum of behavioral health services. It is our intention not to seek further resources for BTKH projects at this time. However, system development work in Alaska will not be completed. Resources already dedicated to BTKH in-state services and system development will continue to support these activities. As described throughout this two-year plan, a number of challenges remain.

Cross system collaboration within DHSS is stronger and has been formalized through the "Joint Management Team" and the "Children's Policy Team". Collaboration within communities and across service providers has also increased and will continue. In addition, in-state community-based and residential behavioral health services have been considerably enhanced.

However, funding and service parameters still create service silos. Transforming these silos into a system of care will require careful structuring of policies, procedures, regulations and funding within DHSS. This work will ensure long-term success at achieving BTKH goals.

We also anticipate a long-term need to support implementation of clinical best practices and to expand services in rural areas of Alaska. Efforts to improve services for youth of transition age, to expand capacity to serve very young children and to effectively serve youth with co-morbidities will also require long-term effort. Currently, long-term performance indicators are being developed. These will include indicators such as admissions to out-of-state residential psychiatric treatment centers, recidivism to residential treatment, measures of community-based service delivery, and to evaluate the impact of specific pilot projects. Data gathering and analysis will direct and modify system development efforts to meet the needs of the children, youth and families in the Alaska behavioral health system.



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January 2011

This comprehensive report on Bring the Kids Home was released by the Department of Health and Social Services, and produced at a cost of $0.95 per copy of 200 in Anchorage, Alaska, for statewide distribution. This cost block is required by AS 44.99.210.