

**Subcommittee for Crisis Prevention and
Intervention, Final Report:**

**The Task Force for Children with Special
Needs**

&

**The Texas Health and Human Services
Commission**

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Acknowledgments

Subcommittee for Crisis Prevention and Intervention, Final Report to the Task Force for
Children with Special Needs

&

The Texas Health and Human Services Commission

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Executive Summary

The Interagency Task Force for Children with Special Needs (TFCSN) created a specialized subcommittee composed of parents, Texas state agency staff from each of the TFCSN member agencies, a representative of a faith-based community organization, and representatives of community service and family-based alternative stakeholder organizations. The role of the subcommittee was to develop recommendations that addressed the TFCSN second priority for implementation, crisis prevention and intervention. The specific goal of the recommendations is to reduce the number of families who experience crisis due to insufficient and/or ineffective interventions or services, or lack of coordination and planning of interventions or services.

Over the past year, the members of the subcommittee have immersed themselves in the work with which the TFCSN entrusted them. Crisis prevention and intervention (CPI) are complex challenges which, when viewed from the perspective of agency collaboration, become even more daunting. This notwithstanding, the group grew into an effective collaboration that brought together multiple perspectives and types of expertise and led to a consensus across participants. The subcommittee itself is proof that cross-agency collaboration such as that envisioned through the recommendations is indeed possible. The subcommittee's vision, definition, and recommendations for positive behavior support (PBS) and local community coordination (LCC) follow. The body of the report includes additional details about these two tactics.

Cost analysis is beyond the scope of this project; however, as the subcommittee studied tactics and crafted recommendations, the members were consistently mindful of fiduciary responsibility and cost effectiveness. The subcommittee believes that more effective use of resources could be realized over the long term, with implementation of the PBS and LCC recommendations presented in this report.

Positive Behavior Support

The Task Force Five-Year Report, along with many other recommendations, identified PBS as a way to improve the lives of children with special needs and their families. The subcommittee decided to explore PBS first and develop their initial recommendation for this topic because:

- Children with special needs often have challenging behaviors, which are frequently a factor in crises, and
- Successful implementation of the PBS recommendations could reduce the need for intensive and/or more expensive services, such as institutionalization or incarceration.



After an extensive study of PBS, the subcommittee created a set of recommendations to develop a statewide network and delivery system of PBS that would ensure children and families receive supports and services that prevent and reduce challenging behaviors and related crises.

PBS changes lives, not just behavior. PBS focuses on increasing quality of life for the child and all family members, rather than simply reducing or preventing challenging behaviors.

PBS Vision Statement

Children with special needs and their families will have the appropriate level of PBS across environments in order to prevent crises and enhance their quality of life.

Definition of PBS

PBS is a set of research-based strategies used to increase quality-of-life and decrease challenging behaviors that may keep a child from reaching his or her full potential. PBS:

- Accomplishes these goals by making changes in a child's environment and teaching new and adaptive skills
- Is oriented to the valued outcomes of children and families and their circles of support
- Applies knowledge of behavioral and other biomedical sciences to gain a comprehensive understanding of the factors (including past traumas) affecting a child's behavior
- Utilizes validated procedures
- Addresses needed systems change from the level of the household to the service delivery system

PBS Core Recommendation

The Crisis Prevention and Intervention Subcommittee recommends that Texas establish a statewide network and delivery system of PBS to ensure that children with special needs and their families receive supports and services that prevent and reduce challenging behaviors and related crises. All Task Force agencies should establish access to this PBS network and delivery system to ensure that PBS services are available to children with special needs across disability groups and service systems. To ensure effectiveness and efficiency, and to build the knowledge base for best practices, implementation progress should be shared and coordinated among all Task Force agencies



PBS Strategies

The Crisis Prevention and Intervention Subcommittee recommends that the Task Force implement the following strategies to fulfill the core recommendation. The strategies apply to all three levels of need (primary/universal, secondary/at-risk, and tertiary/intensive) unless otherwise indicated. The first two of the strategies are foundational in implementing the recommendations as envisioned by the subcommittee.

Foundational Strategies

- Enable and ensure cross-agency collaboration on workforce development, quality assurance, data collection, and reporting.
- Establish a locus of responsibility for the development, delivery, and evaluation of PBS training curricula and practice, including exploration of the development of a PBS Institute for Texas (as successfully accomplished by the state of Kansas through the Kansas Institute for Positive Behavior Support, a partnership with the Kansas University Center on Developmental Disabilities).

Structural Strategies

- Generate broad-based awareness of PBS at the primary (universal) level by including a consistent description of PBS and information about available supports through new and existing sources of training.
- Utilize multiple methods for training delivery, including Web-based materials, print materials, and interactive events.
- Develop criteria for the competency-based training, qualification, certification, and/or supervision of all tiered PBS skill levels (facilitators, service coordinators, and direct support staff) to ensure the delivery of quality services from multiple systems of care.
- Establish access to PBS-trained case managers able to provide person-centered planning and/or wraparound services, and problem-solving consultation at the secondary/at-risk level, as well as early identification of needs for additional supports across environments.
- Provide access to PBS-trained facilitators to deliver PBS services consisting of functional behavior assessment, individualized plan development, and training and coaching to families with children with identified behavioral needs at the tertiary/intensive level.
- Provide prevention-related PBS skill development for family members, caregivers, and/or those who provide direct support to children with special needs.



Local Community Coordination (LCC)

As stated in the Task Force Five Year Plan,

More than coordination, collaboration requires reconceptualization and redirection through engagement of family, local, and state level partnerships in planning and developing agreements to pool expertise, resources, and creativity. Research suggests systemic reforms are successful only in an organizational culture that affirms, supports, and accommodates them. The Task Force is dedicated to working toward that change.

The recommendation for LCC supports the above-mentioned dedication and is designed to help the State establish a new kind of partnership with local communities. The goal is to empower local communities to create and own initiatives, supported by quality outcomes that meet the unique needs of families in their respective communities. This approach represents the paradigm shift fully supported by the TFCSN in its Five Year Plan, as articulated by the following quote:

Children with special needs sometimes require services from more than one agency or program, and the services too often are not coordinated and do not serve the child well. Serving these families successfully requires a commitment to serving the whole child, in the context of the family, through practical, collective problem-solving

Communities would conduct a needs assessment, identify gaps, and submit a plan to develop a CPI system. Development of a CPI plan would require an identified entity to take the lead in pulling together a broad range of community stakeholders, for example parents, caregivers, educators, first responders, law enforcement, local healthcare providers (including hospitals), and representatives from local and state agencies.

The State would partner with the local entity that assumes leadership of the CPI plan and would support the community partner by providing:

- Designated staff to offer technical assistance and support
- Funding to help the community evaluate, plan, coordinate, develop, and enhance resources to increase the number of children and families that receive supports and services that prevent and respond effectively to crises

Texas communities utilizing this approach could more effectively organize and mobilize resources to reduce the number of families who experience crises due to insufficient interventions or lack of coordination and planning of interventions and services. The impact could be to reduce more costly interventions such as emergency room visits, hospitalizations, and/or incarceration.



LCC Vision

Communities are able to create an effectively ongoing process to mobilize and sustain resources to prevent crises for children with special needs and their families and to respond immediately when a crisis occurs.

Definition of LCC

Local community coordination is a collaboration of multiple community members, organizations, agencies, **and family members** who proactively:

- Engage in cross-system planning
- Identify and assess service gaps and obstacles
- Cultivate and make better use of resources
- Develop processes for facilitating and implementing effective CPI strategies for children with special needs and their families

LCC Core Recommendation

To facilitate the development of comprehensive CPI systems across Texas, the State should:

1. Designate staff (by repurposing existing staff, hiring new staff, or outsourcing the responsibility to a contractor) who operate under a community-capacity-building approach to provide technical assistance and support that:
 - Facilitates distribution of such funds as may be available to develop and implement community-based CPI plans
 - Actively engages communities
 - Identifies community champions
 - Provides information about evidence-based and promising practices
 - Provides tools and assistance for assessment and evaluation
 - Helps remove barriers at the state level that prevent families and children with special needs from accessing necessary services and supports for CPI
 - Monitors and participates in evaluating community progress toward execution of a CPI plan
2. Provide funding which is contingent on an acceptable plan with community-identified performance benchmarks tied to the applicable elements of the community's CPI plan. Some communities will be able to incorporate all 12 elements, identified below, to achieve a robust CPI plan; others may need to identify a few key elements as initial goals, with subsequent efforts to put all the elements in place.



3. Partner with a community entity, such as:
- A local mental health authority or local authority for intellectual and developmental disabilities
 - A Community Resource Coordination Group (CRCG)
 - Community coalitions
 - A nonprofit organization
 - A faith-based organization

to assume leadership and support the community in the development of a CPI plan, based on a community assessment and identified needs, that addresses the development of the following elements:

- Formal and informal community networks and relationships that link resources
- Interdisciplinary teams with the capacity to conduct clinical assessments
- Mobile crisis teams with the capacity to effectively respond to a crisis situation involving a child with special needs
- Capacity for formal and informal respite, including scheduled, therapeutic, and crisis respite, offered by competent providers
- Expedited services for emergency and urgent needs
- Child mental health and trauma screening using a common assessment instrument
- Whole-family screening to assess the need for additional social services – for example, behavioral health assessment of siblings – using a common assessment instrument
- Electronic cross-system information exchange of consents, demographic data, and screening and assessment results so that multiple state agencies can access information about the same child and family
- Cross-system training for clinicians, service providers, first responders, and families
- Evidence-based or promising practice peer support for families
- Ongoing community cross-system evaluation of CPI
- Local sustainability plan



Next Steps

The subcommittee gratefully acknowledges the additional time the Task Force gave the group to continue to work together beyond August. This extension gave the subcommittee time to explore the complex issues related to PBS and LCC more fully and to develop overarching recommendations for both tactics. Still to be developed is a table of implementation options for LCC, an additional level of detail to parallel the table for PBS.

Twelve other tactics (see page 10) identified by the subcommittee deserve consideration, as do a number of interconnected ideas that surfaced repeatedly during the subcommittee's discussions. The following topics of particular importance emerged, and any one of them would be a natural place to begin future planning efforts. Additional information for these five topics is on page 41.

- Family resource specialist/comprehensive case manager/support coordination
- Peer support
- Respite
- Training
- Workforce development



Introduction

During the 81st Legislature, Regular Session 2009, Senate Bill 1824 established the Interagency Task Force for Children with Special Needs (TFCSN) to "improve the coordination, quality, and efficiency of services for children with special needs." The TFCSN created and produced a Five-Year Plan from which it identified and selected two initial priorities for evaluation and implementation. This report addresses the second of those priorities, Crisis Prevention and Intervention (CPI). Section 115.004 (b) (2) of Bill 1824 specifies:

The plan created under this chapter must provide recommendations to reduce the number of families who experience crisis due to insufficient and ineffective interventions or services or lack of coordination and planning of interventions or services.

To address this requirement, the TFCSN created a specialized subcommittee composed of parents, Texas state agency staff from each of the TFCSN member agencies, a representative of a faith-based community organization, and representatives of community service and family-based alternative stakeholder organizations.

The subcommittee's mission was to fully develop and communicate specific recommendations from the TFCSN Five-Year Plan that are informed, locally focused, interagency CPI recommendations. This report provides recommendations for positive behavior support (PBS), local community coordination (LCC), and continued agency collaboration.



The subcommittee initially identified four strategies and 14 tactics that would serve as the foundation for developing specific recommendations. (See the model on page 9.) The subcommittee prioritized and selected PBS and LCC as its first two tactics and recommends continued investigation and planning on the remaining tactics. The depth of study based on the Task Force Five-Year Plan is extremely important to subcommittee members. The recommendations in this report for PBS and LCC represent widespread cultural change, which would set the stage for future development of recommendations on the remaining tactics. The group selected PBS as the first tactic to explore for several reasons.

- PBS was a goal adopted in the TFCSN Five-Year Plan.
- PBS is a strategy well suited for collaboration among the TFCSN agencies.
- Children with special needs often have challenging behaviors, which are frequently a factor in crises.
- Statewide implementation of PBS could positively impact many children with special needs, as well as their families, health care providers, educators, and others involved with the child.
- Successful implementation of the PBS recommendations could reduce the need for intensive and/or more expensive services, such as institutionalization or incarceration.
- Prevention strategies are more likely to reduce the need for crisis intervention, thereby producing better outcomes for children, families, and the community.

As its second strategy, the subcommittee decided to explore ways to strengthen LCC and linkages, following the rationale that LCC:

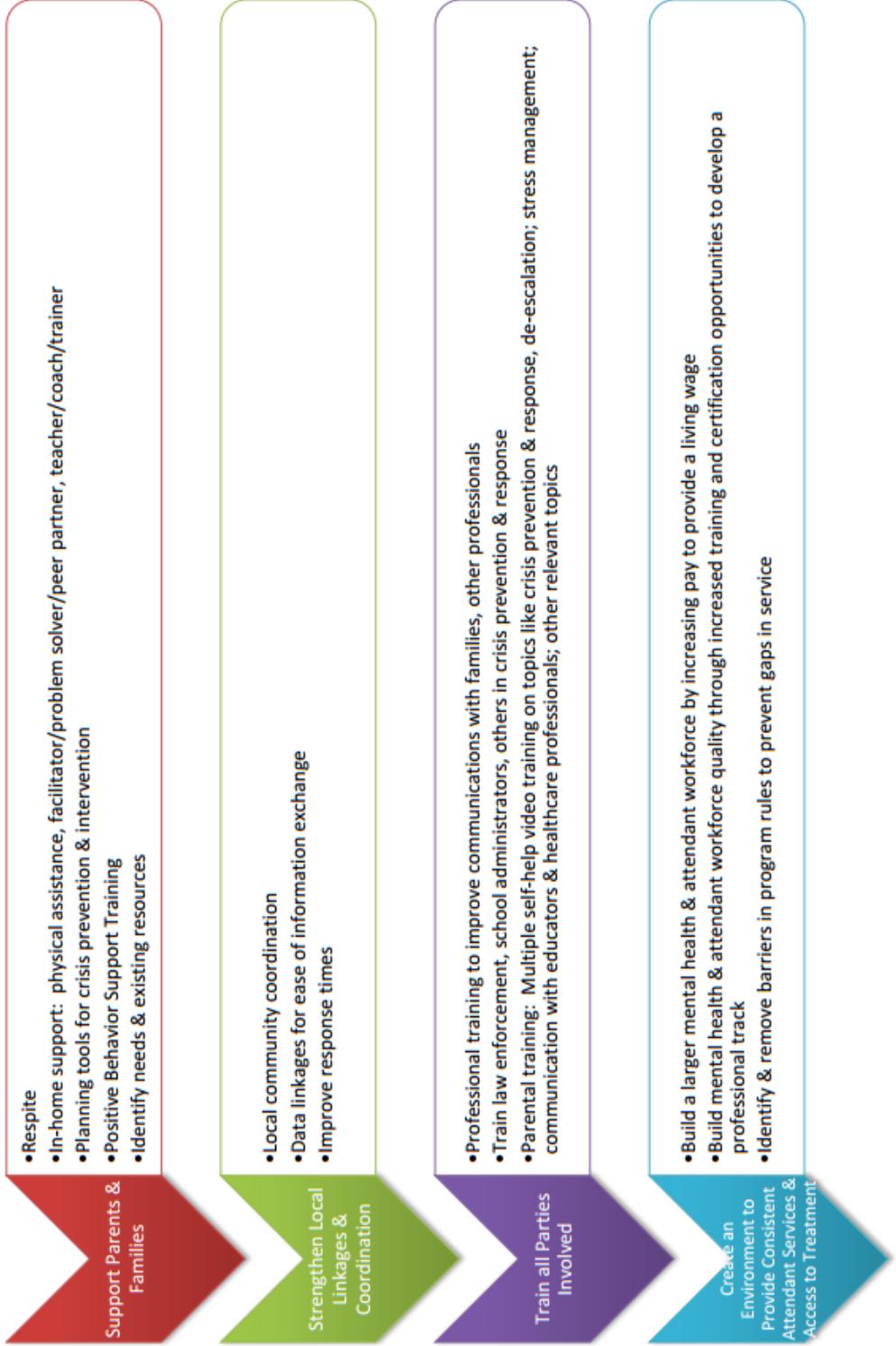
- Is foundational and encompasses many of the other tactics
- Incorporates interagency coordination and collaboration, which aligns with TFCSN recommendations
- Focuses on the community level where the subcommittee has been tasked to work – representing a paradigm shift to manage the problem “where it is”
- Respects diversity of communities and acknowledges that not every community has the same resources
- Addresses fragmentation of services and improves communication, making realization of recommendations for other tactics, such as respite, easier to implement
- Optimizes resources, reducing duplication and inappropriate services



GOAL: ENHANCE & INCREASE THE EFFECTIVENESS OF CRISIS PREVENTION & INTERVENTION FOR CHILDREN & FAMILIES OF CHILDREN WITH SPECIAL NEEDS

STRATEGIES

TACTICS



Positive Behavior Support

PBS Problem Statement

Thousands of children across Texas experience injuries, restraints, school suspensions, arrests, or placements away from their families as a result of lack of access to effective supports to reduce or prevent challenging behaviors. Parents of children with special needs struggle to support their children, yet they lack access to services and training that teach them about challenging behavior and its prevention. Without access to effective supports and services, families may face untenable situations such as:

- Having to choose between work and staying home to care for a child
- Having to choose between attending to the child with special needs and attending to their other children
- Relinquishing parental rights
- Institutionalization of the child

Without access to training and knowledge, many families face painful but avoidable crises. PBS is an approach that could potentially result in demonstrable improvement in these situations. By offering families supports that have demonstrated efficacy, the Texas service system could improve the efficiency and effectiveness of its existing limited resources.

Overall, there is both a lack of access to behavior support services and a shortage of behavior support providers across service systems. When providers are available, behavior support services can be unaffordable for families. Even when available and affordable, there is no assurance that providers of behavior support are applying an evidence-based practice such as PBS. Many providers lack training in PBS. The State's required qualifications for behavior support providers do not call for PBS competency or for a review of the quality of the behavior support services provided. As a consequence, families and direct support staff have neither access to PBS services nor opportunities to develop effective prevention-related skills.

Currently, there is wide variability among state agencies regarding the capacity and competency of behavior support providers, as well as regarding the quality of behavioral support practices in general (and PBS in particular). Furthermore, there is no organized delivery system to offer community-based PBS, nor is there a locus of responsibility tasked with promoting PBS across and within state agencies and local entities.

The Task Force has identified PBS as a way to improve the lives of children with special needs and their families. In response, the subcommittee has developed a set of recommendations to develop a statewide network and delivery system of PBS that would ensure that children and families receive supports and services that prevent and reduce challenging behaviors and related crises.



Definition of PBS

Positive behavior support is a set of research-based strategies used to improve quality of life and decrease challenging behaviors that may keep a child from reaching his or her full potential. PBS:

- Accomplishes these goals by making changes in a child's environment and teaching new and adaptive skills
- Is oriented to the valued outcomes of children and families and their circles of support
- Applies knowledge of behavioral and other biomedical sciences to gain a comprehensive understanding of the factors (including past traumas) affecting a child's behavior
- Utilizes validated procedures
- Addresses needed systems change from the level of the household to the service delivery system

How PBS Works

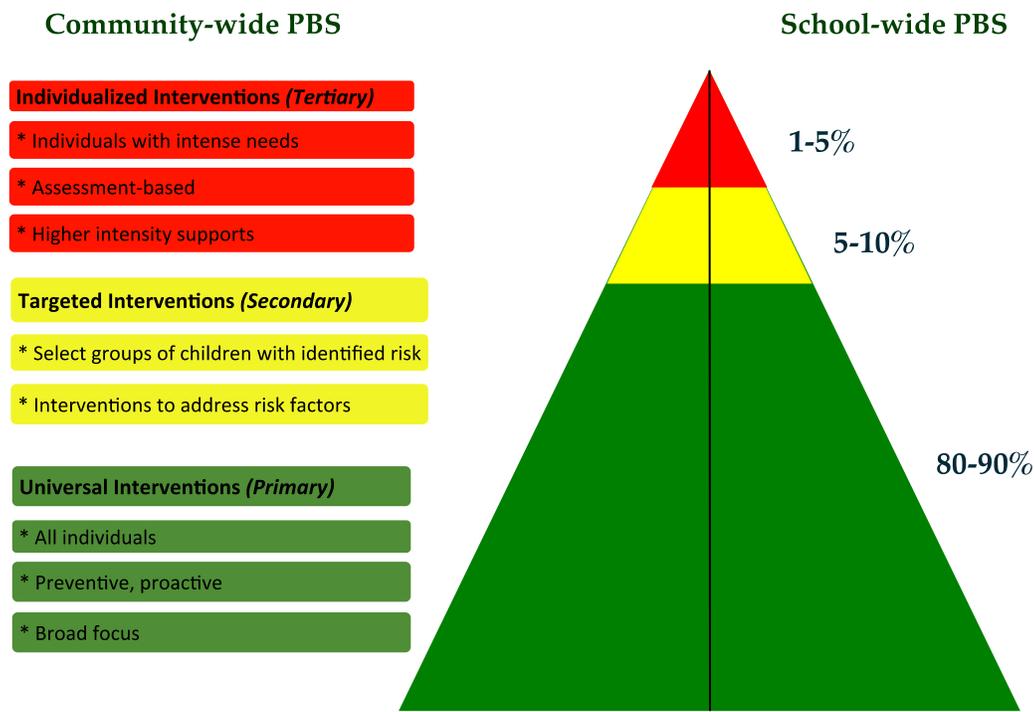
PBS offers a multitiered system of support for families of children with special needs, including:

- Planning processes with team-based wraparound¹ and person-centered planning (PCP)
- An emphasis on the prevention of challenging behaviors
- At the primary (or universal) level, interventions designed to promote pro-social behavior and prevent undesirable behavior across all children with special needs
- At the secondary (or at-risk) level, interventions targeted to those children at increased risk of developing significant challenging behaviors
- At the tertiary (or intensive) level, concentrated intervention for children engaging in significant challenging behaviors. At the tertiary level, PBS services include:
 - A functional behavior assessment (FBA) to determine the purpose (function) of challenging behavior before developing interventions. The FBA is administered by a trained provider
 - Development of an individualized plan based on the FBA
 - Training and coaching of families and support staff
 - Monitoring of plan implementation and revision
 - Implementation by a PBS-trained facilitator who is knowledgeable about PBS and possesses an advanced set of skills and qualifications to provide PBS services

The following diagram provides an illustration of the three tiers/levels described above. The percentages next to the pyramid represent percentage of students.

¹ Wraparound is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities as defined by the National Wraparound Initiative.





Adapted from Sugai, 2002

The World Without PBS

Lack of access to effective behavior supports has consequences in real lives and in system costs and inefficiencies.

Alex was a young boy with a disability who lived with his family. His parents cared for him deeply, but found his high activity level and challenging behaviors difficult to manage. Though they wanted help with his behavior, they were unable to find appropriate support. When they could no longer protect Alex and manage their family and work lives, Alex was offered placement in a state supported living center, one of the State's most expensive service options.

Sally was a typically developing young girl until a medication reaction resulted in her developmental disability. She lived with her family until she was a teenager, at which time her challenging behaviors at school and home began to threaten her father's ability to maintain a job. Her father was unable to obtain behavior support, and Sally was placed in a state supported living center at considerably higher expense than the support her family needed.

Carol was the most difficult child in her school and perhaps her school district. Identified as having a disability, Carol was also a victim of bullying, which led her to become highly aggressive. Carol was highly defiant, belligerent, and angry; her challenging behaviors resulted in restraints and suspensions from school. She was arrested twice (at age 10 and age 11) by a school resource officer.

Each of these children and families could benefit from PBS.



PBS Research and Best Practice

Studies offer evidence of the effectiveness of PBS when implemented with fidelity.

- A research synthesis of 109 peer-reviewed studies² found that PBS intervention results in an 80% reduction of challenging behaviors in 67% of all cases and a 90% reduction in half of all cases.
- When School-wide PBS is implemented to criterion, results indicate the following improvements in academic and social behavior outcomes:
 - A 20%-60% reduction in office discipline referrals for students with and without Individualized Education Programs
 - Increase in amount of time students spend in instruction
 - Decrease in amount of time administrators and teachers spend addressing problem behaviors
 - Improvement in perception of school safety and mental health
 - Reduction of students identified for tertiary interventions
 - Reduction of office discipline referrals and student suspensions, saving teaching days, learning days, and administrator days

Kansas offers PBS and PCP facilitation in its Medicaid State Plan services for any child (under age 22) who is eligible for Medicaid. With prior authorization, a child may receive up to:

- Thirty hours of FBA (at \$40 per hour)
- Sixty hours of PBS treatment (at \$100 per hour)
- Forty hours of PCP (at \$40 per hour)

for a maximum cost of \$8,800 for 130 hours of support spread across a 12-month period.

Authorizations for a second year of service are possible but unusual.

- In an analysis of 120 cases using PBS facilitation, a risk assessment scale completed by family members before and after services found that they reported less risk in all items, with the most change in the following:
 - Problem behaviors occurring at a “frequency and intensity that caregiver’s support is being compromised”
 - Problem behavior is likely to become “serious and will be of concern in the near future if not addressed”
 - Problem behavior “puts them at risk of institutionalization ...”

² Carr, E.G., Horner, R.H., Turnbull, A.P., Marquis, J.G., Magito McLaughlin, D., McAtee, M.L., Smith, C.E., Anderson Ryan, K., Ruef, M.B., & Doolabh, A. (1999). *Positive behavior support for people with developmental disabilities: Research synthesis* (American Association on Mental Retardation Monograph Series). Washington, D.C.: American Association on Mental Retardation.



PBS Cost Effectiveness

The question of cost effectiveness must be considered in relation to the status quo. Currently, children with special needs such as Alex, Sally, and Carol, who engage in challenging behaviors and do not receive adequate or appropriate support, may entail significant financial costs, such as:

- Costs of injuries resulting from challenging behaviors that require medical care, resulting in expenses of trips to hospital emergency rooms (\$1000-\$1200 daily cost of an emergency room visit) and/or expensive short-term hospitalization (\$400 daily cost at state hospital)
- Cost of deployment of first responders
- Potential costs in the foster care system
- Significant risk of losing the ability to live with their family, resulting in the extraordinary costs of institutional placement
 - \$620 daily cost of state supported living center
 - \$140 daily cost in a non-state-operated intermediate care facility³

These costs take a toll on state resources and can be contrasted with the maximum cost of PBS offered by the Kansas state plan, which is \$24 per day when averaged across 365 days.

The World with PBS

PBS changes lives, not just behavior. PBS focuses on improving quality of life for the child and all family members, rather than simply reducing or preventing challenging behaviors. With PBS, the lives of children like Sally and Alex could be very different. Carol's life changed because of PBS. She is one of the fortunate children in Texas whose school embraced PBS.

Carol's story, continued ...

After only three weeks in a school with a PBS environment, Carol became open to social interaction, engaging and showing the beginnings of empathy. Her mother reports that her turnaround was immediate. Carol is now a role model and peer model in her school and anticipates a bright future.

PBS also changes the behavior of those in the children's environment. Like Carol, the lives of children in many Texas schools are being changed by school-wide PBS interventions. Positive Behavior Interventions and Supports (PBIS) is an application of PBS designed to be implemented throughout schools and school districts. When implemented with fidelity, PBIS improves the behavior of students by effecting change in the behavior of teachers and administrators. As the school environment changes, student behavior improves.

³ As provided by HHSC Strategic Decision Support.



Rita Cundieff, Principal of Velasco Elementary School, reflects that before PBS, her office was a revolving door of students frequenting the office for hitting, pushing, insulting, and not following classroom rules. It was clear that discipline incidents were adversely affecting academic performance. After attending a presentation describing schools that had implemented school-wide PBS, the school administration made the decision to implement PBIS. Ms. Cundieff reflects on the results⁴:

.... as our efforts persisted, we began to see small changes in student and teacher behavior. The [second] year, we built on efforts from the previous year. ... Our student recognition efforts improved, our lesson plans were refined, and our discipline referral numbers decreased. Our third year, we refined the other components of PBIS in the individual classrooms, which brought on an even bigger improvement in managing student behavior. [Our fourth year] I was able to remove the student-sized chairs from outside my office, that for so long had served as an image of life before PBIS. PBIS has become the norm on our campus today, and positive images such as smiles, hugs, and students cohabitating our school in an orderly, focused manner come to mind when I reflect on the impact that PBIS has made.

In Texas, a comparable effort has not yet been organized to promote PBS outside of school settings. However, in other states, such as Kansas, South Carolina, Virginia, West Virginia, Washington, and Minnesota, PBS has been more widely adopted. For example, Kansas created a locus of responsibility for promotion of PBS for children with special needs. The initiative began in the developmental disabilities system but has since expanded to the mental health and child welfare systems. This comprehensive effort has resulted in the expansion of cross-system capacity, increase competency, and assure quality. Presented below is the story of one child in Kansas.

Jessica is a 7th grader. When she was four years old, she was placed in foster care due to severe abuse and neglect. Her foster family reported that when Jessica is distressed, she bites herself and others, resulting in injuries requiring emergency treatment. She was referred for PBS services, which included PCP and an FBA that revealed that Jessica bites herself or others when she perceives a threat. The team identified environmental factors and activities to help reassure her. The plan focused on changing her activities and her schedule, teaching her how to request a change in environments when she feels distressed, and using a scrapbook and photo albums of her friends and family that she can review for reassurance. After putting the plan into effect, calls from the school to pick her up have decreased from once a week to once a month, and she has not been to the emergency room for bites in four months.

⁴ Quote used with permission.



Both the Texas school-wide experience and the Kansas model to build community capacity are examples of what is possible when PBS is promoted through a concentrated effort. In a Texas with PBS:

- Children with special needs could live in a family environment attuned to their needs, where they learn new skills and experience fewer crises, thereby decreasing challenging behaviors and improving their quality of life.
- Families could receive services and supports and could have the knowledge and skills to create a responsive environment and teach their children skills, thereby decreasing challenging behaviors, reducing crises, and improving their quality of life.
- Texas could have a statewide network and delivery system that ensures effectiveness, efficiency, and availability across disability groups and service systems, thereby reducing the number of families that experience crises due to insufficient and ineffective interventions or lack of coordination and planning of interventions and services.



PBS Strategic Recommendations

Vision Statement

Children with special needs and their families will have the appropriate level of PBS across environments in order to prevent crises and enhance their quality of life.

PBS Core Recommendation

The Crisis Prevention and Intervention Subcommittee recommends that Texas establish a statewide network and delivery system of PBS to ensure that children with special needs and their families receive supports and services that prevent and reduce challenging behaviors and related crises. All Task Force agencies should establish access to this PBS network and delivery system to ensure that PBS services are available to children with special needs across disability groups and service systems. Implementation progress should be shared and coordinated among Task Force agencies to ensure effectiveness and efficiency, and to build the knowledge base for best practices.

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- Establish a locus of responsibility for the development, delivery, and evaluation of PBS training curricula and practice, including exploration of the development of a PBS Institute for Texas (as successfully accomplished by the state of Kansas through the Kansas Institute for PBS, in partnership with the Kansas University Center on Developmental Disabilities).



Structural Strategies

- Generate broad-based awareness of PBS at the primary (universal) level by including a consistent description of PBS and information about available supports through new and existing sources of training.
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- Develop criteria for the competency-based training, qualification, certification, and/or supervision of all tiered PBS skill levels (facilitators, service coordinators, and direct support staff) to ensure the delivery of quality services from multiple systems of care.
- Establish access to PBS-trained case managers able to provide PCP and/or wraparound services, problem-solving consultation at the secondary/at-risk level, as well as early identification of needs for additional supports across environments.
- Provide access to PBS-trained facilitators to deliver PBS services consisting of FBAs, individualized plan development, and training and coaching to families with children with identified behavioral needs at the tertiary/intensive level.
- Provide prevention-related PBS skill development for family members, caregivers, and/or those who provide direct support to children with special needs.



Improving PBS in Texas: Current Status and Future Opportunities

Many state agencies provide interventions that make a positive difference for children and their families. However, these interventions tend to focus primarily on managing the child's behavior and do not include PBS's focus on PCP and improving quality of life for the child and family. Nor do these interventions emphasize changing the environment, including exploring the elements in the environment that contribute to challenging behaviors. Furthermore, state agencies often work within the narrow focus of their target population and lack the cross-agency coordination required in Senate Bill 1824. The following are highlights of current agency status and future opportunities; more information is available in Appendix C.

Texas Juvenile Justice Department (TJJD)

The implementation of PBS in the education programs of secure facilities in TJJD has decreased disciplinary referrals involving physical restraint, raised academic performance, and lowered the number of incidents involving youth eligible for special education services. Due to positive outcomes of PBIS in the education settings, TJJD will implement PBIS facility-wide (e.g., dorm life settings) as its behavior management model. TJJD is currently in the installation phase of rolling out a plan to begin initial training/implementation of the model in January 2014.

Health and Human Services Commission (HHSC)

HHSC has no formal programs utilizing PBS at this time. However, effective in September of 2014, there will be opportunities to incorporate the PBS model into the Mental Health Rehabilitation and Targeted Case Management services that will become Medicaid managed care services.

Department of State Health Services (DSHS)

The Mental Health and Substance Abuse (MHSA) Division of DSHS supports the philosophy of PBS. DSHS/MHSA supports families' having access to PBS providers. Although PBS is not a formal part of the array of children's mental health services at present, those services (when indicated and desired by the family) may be purchased using MHSA "flex funds" or through other funding mechanisms, such as the Youth Empowerment Services waiver designed to help youth avoid repeated psychiatric hospitalizations. The Children with Special Health Care Needs (CSHCN) Services Program within the Family and Community Health Services (FCHS) Division currently does not have programs that fit the definition of PBS directly; however, the CSHCN Services Program does provide health care benefits and case management services, which might enable a client to initiate or coordinate access to some PBS services. Both DSHS divisions promote evidence-based practices that are consistent with the principles and philosophy of PBS. DSHS staff members, community-based local mental health authorities (LMHAs), and other contractors can facilitate pathways to and funding of services provided through other state programs. Also, DSHS has staff that might participate in furthering PBS through training and interagency collaboration.



Department of Family and Protective Services (DFPS)

DFPS currently has no formal PBS approaches. DFPS does use opportunities to work with other agencies to conduct FBAs and help children move out of facilities. DFPS also works in partnership with and in support of schools that offer PBS.

Texas Education Agency (TEA)

TEA provides considerable financial support and policy guidance on PBIS to all 20 regional education service centers (ESCs) through the Texas Behavior Support (TBS) Initiative, which was established in response to Senate Bill 1196, 77th Legislature, Regular Session, 2001. Led by the Region IV ESC (Houston), the initiative provides capacity-building training and technical assistance for school districts and charter schools. The goal is to create a PBS system in the Texas public schools to provide tiered interventions for campus, targeted, and individual behavior planning that will enable students with and without disabilities to receive PBIS, an application of PBS designed to be implemented in schools. Currently, there are almost 400 campuses in Texas participating in the National Benchmarks of Quality Study of PBIS. Staff at over 600 campuses (representing approximately 5% of the total number of campuses in Texas) serving an estimated 480,000 Texas public school students have been trained in the last two years and are in some stage of implementing multitiered PBIS for all students in general and special education. TEA and the Texas Behavior Support Network are exploring ways to increase the number of students served and to identify indicators of effectiveness for PBS in schools. These entities are also eager to serve as resources and collaborate with a community-based system of PBS.

Department of Aging and Disability Services (DADS)

DADS offers Positive Behavior Management workshops and has informational resources on PBS in development, including a behavioral health Web page. DADS has also contracted with a vendor to identify service providers for behavioral support services, including PBS.

The table below includes specific options for how the PBS recommendations might be implemented.



PBS Implementation Options	
Level	Implementation Option
All children with special needs <i>(Primary/Universal)</i>	1. Develop an Office of Positive Behavior Support Coordination 2. Make family-oriented PBS awareness-raising activities and prevention-related skills training available to all families of children with special needs <ol style="list-style-type: none"> a. Develop multiple information sources, including Web-based materials, print materials, and interactive events, such as conference presentations and workshops b. Promote the incorporation of PBS into the many existing parent education efforts c. Provide this information to families (including foster families), communities, educators, first responders, crisis response teams, health care professionals, and relevant agency employees, contractors, and providers 3. Build on existing Region IV ESC training for school staff to include anyone who provides behavior services to students with special needs 4. Collect evaluation data on existing campus- and school-district-level PBS programs to ensure cost effectiveness and identify results
	5. Establish PBS training requirements and cross-system planning coordination guidelines for service coordinators/case managers
	6. Provide a PBS-trained service coordinator/case manager for PCP and/or wraparound services, behavioral problem-solving, and early identification of need for more intensive supports
	7. Develop and provide competency-based PBS training for direct support staff for children with challenging behaviors <ol style="list-style-type: none"> a. Require for providers of Medicaid waiver services b. Require for providers of Medicaid state plan new skills training benefit under Community First Choice 8. Adapt or develop evaluation tools to establish cost effectiveness and identify results
Targeted/at-risk <i>(Secondary)</i>	9. Provide targeted access to in-home PBS-trained direct support staff.

PBS Implementation Options

Level	Level
Intensive <i>(Tertiary)</i>	<p>10. Provide access to a PBS-trained facilitator to provide PBS services consisting of FBA, individualized plan development, training, and coaching for families with children with identified behavioral needs</p> <ul style="list-style-type: none"> a. Expand the list of qualified Medicaid providers of behavior supports to include certified PBS facilitators b. Put PBS services in all waivers c. Ensure a definition of services consistent with the recommendations d. Include PBS services in the Medicaid state plan <p>11. Build on existing service systems by using local coordination groups such as Community Resource Coordination Groups (CRCGs), special education admission, review and dismissal committees (ARDs), and emerging transformation grant initiatives, to provide more coordinated care and/or access to PBS facilitators</p>
	<p>12. Ensure the competency of PBS-trained facilitators</p> <ul style="list-style-type: none"> a. Develop competency-based training criteria and practice qualifications of PBS facilitators b. Develop and implement a quality assurance process for reviewing PBS facilitator practice c. Develop a locus for the development and delivery of PBS training curricula and competency-based evaluation of trainees d. Explore partnerships with university institutes (e.g., University Centers for Excellence in Developmental Disabilities) for development of a PBS institute (e.g., Kansas Institute for Positive Behavior Support)
	<p>13. Publicize and exploit linkages with local crisis response teams</p> <ul style="list-style-type: none"> a. Develop disability and PBS awareness training for first responders and local or school-based crisis response teams and school resource officers b. Ensure linkage to an in-home PBS facilitator for children with special needs who are accessing local crisis response teams



Local Community Coordination

LCC Problem Statement

Like many families, Texas families of children with special needs experience crises during their lives. Some families face struggles that culminate in an episode requiring an urgent community response. Many of these families lack access to the specific services and supports that could have reduced the likelihood of that crisis.

Many communities have some crisis response capability, but it is often disjointed, serves only specific subpopulations (e.g., persons with behavioral health issues but not developmental disabilities, or persons with behavioral challenges but not medical disabilities), or deploys responders too late or with insufficient tools. Likewise, many communities have limited ability to prevent crises. Communities that lack intentional, community-level, community-wide planning may fail to take full advantage of potential resources. These communities may be unaware of evidence-based approaches to CPI or unable to provide them.

Overall, the nature of the current relationship between state agencies and local communities is one of limited partnership. State requirements are imposed on communities through contracts that prescribe how state resources may be used, while many communities are left with crises for which resources are inadequate or for which potential responses are constrained. State funding and requirements tend to be agency- or program-specific and often do not take into consideration the cross-system implications. Rarely is the relationship one that focuses on cross-system community building whereby the State supports and assists local communities to develop the services that most closely match their needs.

Currently, there is wide variability among communities regarding CPI capacity, competency, and quality. Even when a community prioritizes the development of better CPI, participants often struggle with no single entity's clearly assuming responsibility for community-wide needs assessment or planning. There is no consistent mechanism for ensuring that successes within and outside Texas are shared across Texas communities.



The World without Comprehensive LCC

Lack of comprehensive LCC has consequences for real lives and in system costs and inefficiencies.

Michelle's mother has mental health problems (depression, history of domestic violence and substance abuse) and recently underwent surgery for a serious medical condition. She and her children live in public housing without natural supports. Consumed with attempting to care for her children, she is often immobilized by chronic clinical depression and generally feels defeated by life. Her youngest daughter's serious mental illness overwhelms her parenting strategies. The children are frequently absent from school and failing all subjects. Michelle, age 15, was removed from her home by CPS workers. Michelle has clinical depression and, before removal, stayed in her room most of the time, was unresponsive to requests, and reported feeling lost and sad. Michelle's mother had stopped attempting to access community support services to address her own needs and the behavioral health, medical, and educational needs of her children. A lack of reliable transportation exacerbated the situation. She simply lacked the physical and emotional energy to navigate multiple community resources and had given up hope of a better life.

Jimmy has moderate cognitive impairments and autism. He has lived with his family all of his life, and they want to continue to have him with them. They have tried to access family support for many years, but Jimmy has been excluded from out-of-home respite services because of ongoing severe self-injury and major property destruction. His family has been in constant crisis. His behavior problems have often been severe and out of control. He has been hospitalized in psychiatric facilities on numerous occasions, and after each admission he seemed worse.

Bethany is seven years old and has been diagnosed with depression and oppositional defiant disorder. Her mother is 29 and appears to have developmental delays which impact her behavior and parenting skills. Her mother has never worked and receives Supplemental Security Income. She lacks social, grooming, and dressing skills. The nontraditional family includes Bethany's mother, her two children, her ex-husband (the father of her children), his wife, and their two young children. Although unusual, family members report mutual support from each other. All members of the family have medical and/or mental health problems. In the recent past, the family has experienced the death of seven friends or extended family members who previously provided supports to the family. When CPS visited the home, the worker reported a very dirty and chaotic environment. The worker observed significant conflict, including mutually aggressive behavior between Bethany and her mother.

Each of these families faces difficult situations and has members with significant needs in addition to the child identified with a special need. Without a comprehensive individualized response that is multifaceted and well-orchestrated, these families will experience crises and supports will be ineffective as well as inefficient.



Definition of LCC

Local community coordination is a collaboration of multiple community members, organizations, agencies **and family members** who proactively:

- Engage in cross-system planning
- Identify and assess service gaps and obstacles
- Cultivate and make better use of resources
- Develop processes for facilitating and implementing effective CPI strategies for children with special needs and their families

Examples of LCC

The subcommittee studied a number of promising approaches to LCC and carefully considered whether to recommend specific models for replication statewide, or to recommend that communities implement the elements that distinguish these successful approaches. After hearing from a local community engagement specialist who underscored the importance of maintaining the autonomy of the community, the subcommittee decided instead to identify and recommend critical components.

Drawing from four promising approaches to LCC, the subcommittee identified 12 elements that a robust CPI system should have. These elements are listed on page 5 and 6 of the Executive Summary and on page 34 below. Every community is different. Some communities will be able to incorporate all 12 elements to achieve a robust CPI plan; others may need to identify a few key elements as initial goals, with subsequent efforts to put all the elements in place. A brief description of the four approaches follows.

Community Resource Coordination Groups (CRCGs)

In 1987, the Texas Legislature passed Senate Bill 298, which directed state agencies to develop a community-based approach to better coordination of services for children with complex needs. CRCGs were developed in response to this legislation. These groups develop service plans for individuals and families whose needs can be more efficiently met through interagency coordination and cooperation. CRCGs are organized and established on a county-by-county basis. They identify gaps as well as appropriate resources and supports that would meet the needs of the child and family. Members represent public- and private-sector agencies and organizations, as well as parents, consumers, and caregivers.

In practice, CRCGs vary greatly across counties. Some are able to link families to additional services, while others are unable to provide any resources or referrals beyond what the family has already attempted to access. CRCGs miss important opportunities to be more efficient and effective because they convene only **after a crisis has occurred**, or when families are desperate, rather than working with the family to help **prevent a crisis**. In the past, a number of positions dedicated to supporting CRCGs were funded at the state level; however, state funding for CRCGs was suspended in 2011.



The subcommittee recognized that CRCGs are not comprehensive CPI initiatives. CRCGs were charged only with assisting individual families after a crisis, not with looking at prevention. In addition, CRCGs worked only on coordination on a case-by-case basis, not on changing community-wide gaps in the system. However, the subcommittee recognizes the value of these formal cross-agency community networks, which already exist in every county. With incentives and technical assistance from the State, CRCGs could become an efficient and cost-effective starting point for more comprehensive planning, especially if they expanded their focus to include crisis prevention as well as intervention, and if they began to address system-level gaps rather than convening only to assist a specific child and family.

Systemic, Therapeutic, Assessment, Respite and Treatment (START)⁵

Founded in 1988 by the Massachusetts Department of Developmental Services, START is a comprehensive evidence-based model of crisis prevention and intervention services that optimizes independence, treatment, and community living for individuals with intellectual and developmental disabilities (IDDs) and behavioral health needs (dual diagnosis).

START was cited as a model program by the U.S. Surgeon General's Office in the 2002 report, *CLOSING THE GAP: A National Blueprint to Improve the Health of Persons with Mental Retardation*. The Center for START Services was founded in 2009 at the Institute on Disability at the University of New Hampshire to respond to a nationwide demand to develop START services and provide technical support, education, and guidelines to ensure fidelity to the model. START is a proprietary fee-based model.

Programs modeled on START have been implemented nationwide. Currently, Fort Worth and Travis County are in the early stages of implementing START programs through 1115 waivers. Their experiences should be closely watched and successes shared with other communities.

The Center for START Services provides technical support, clinical expertise, and training and consultation services that support the development of:

- Comprehensive evaluation of services and systems of care (local and state)
- A systems linkage approach to service provision
- Expert assessment and clinical support
- Outcomes-based research and evaluation
- Short-term therapeutic respite opportunities
- Cross-system crisis prevention and intervention planning
- Family support, education, and outreach
- Interdisciplinary collaboration

⁵ <http://www.centerforstartservices.com/about/default.aspx>

START is an evidence-based program model with documented benefits and outcomes, including

- Reduced use of emergency services and state facility/hospital stays
- High rates of satisfaction of families and care recipients
- Cost-effective service delivery
- Increased community involvement and crisis expertise in communities
- Strengthened linkages that enrich systems, increase resources, and fill in service gaps
- Increased professional and logistic linkages among service providers in multiple disciplines
- Improved expertise across systems of care
- Services designed to fill service gaps

START stood out to the members of the subcommittee because of its strong focus on improving whole systems of care; local evaluation, planning, and coordination of crisis prevention and intervention across the system (rather than having individual agencies approach CPI in a patchwork way); identification of a community entity to lead comprehensive CPI improvement; access to expert assessment, clinical support, and therapeutic respite; and family involvement and supports. These elements are reflected in the subcommittee's recommendations for LCC.

Bexar CARES ⁶

Established in 2011 by the Texas Legislature as a two-year pilot project, the intent of Bexar CARES is to improve outcomes for children through early identification of behavioral health problems and to prevent the escalation of behaviors that place children at risk for educational failure, removal from family and community, and engagement with the juvenile justice system. Subsequent legislation has extended Bexar CARES through 2023.

Bexar CARES has successfully created a process for cross-system coordination to expedite intervention at the earliest point possible to maximize positive outcomes for children and youth and their families while minimizing overall system costs. The project began in San Antonio as a partnership between the LMHA, Child Protective Services, and the Juvenile Justice System. It has recently expanded to include a local school district and the Education Service Center for Region 20. Early identification of behavioral health issues and intervention can make the difference between “dropping out” and successful completion of high school, with the cost associated with each outcome varying significantly.

⁶ Taken from annual reports from the Bexar CARES project, with edits by Leanne Lindsey, Bexar CARES staff member at the Center for Health Care Services in San Antonio, Texas.



One key feature of Bexar CARES is a shared data system, which has allowed electronic data sharing across participating systems. The Efforts to Outcomes (ETO) software allows for real-time data sharing and access to limited but important information. In practical terms, this system makes it easier for families, who only have to provide demographic data once and complete a single consent and release form, which applies to all participating agencies. ETO also makes coordinating across agencies easier because all have immediate access to the child's behavior assessment and to information about other family members. The database is conveniently accessible through laptops in the field.

Bexar CARES employs screening tools, including the Pediatric Symptom Checklist for early identification and intervention for children with behavioral health issues and their families. The project has created a "no wrong door" environment for families who touch multiple systems.

The subcommittee was especially impressed with Bexar CARES's shared data system and with the fact that, because of the enabling legislation, participating agencies could use a common behavior assessment and consent/release form and share information about the child and family. Early assessment of behavioral health issues and whole-family screening beyond the identified client were also notable features. Both ideas are reflected in the LCC recommendations. While this project focuses exclusively on the mental health side, the structure would be equally effective for families with children with developmental/intellectual disabilities and children outside the CPS system, if the partnership were expanded to include relevant agencies.

Turning Point

Turning Point⁷ is a pilot program designed and implemented by Superior Health Plan Network, the STAR Health managed care organization (MCO), as a way to avoid unnecessary acute psychiatric hospitalizations and increase placement stability. The program provides community-based therapeutic respite at a ten-bed group home staffed 24/7. It serves children in foster care age 10 to 17 in CPS Region 3 who are at a point of crisis but may not yet need hospitalization. Turning Point allows children to continue school while in respite, return to the same foster family, and maintain their current community relationships with minimal changes. The foster parents are involved as part of the treatment team and are provided with behavior management and trauma-informed training, as well as ongoing necessary supports to help the child return to the foster family.

The program, a partnership of ACH Child and Family Services, Cenpatico, and Empirica, has increased collaboration among treatment providers and across crisis intervention providers, the outpatient treatment team, and foster families.

⁷ <http://www.achservices.org/turningpoint.html>

The program offers:

- Short-term residential respite
- Full mental health evaluations and medication audits
- Intensive counseling
- Personalized planning and consultation for the entire foster family
- Support and plans of service for post-reunification

The subcommittee was impressed with the increased collaboration among providers and with families, as well as the program's ability to offer immediate relief to children and their foster families at the point of a crisis, without hospitalizing the child. The involvement of the foster family as an active partner in the therapeutic intervention during the respite placement serves as a bridge to successful return home.

Although the program is small and new, its ability to reduce hospital admissions and re-admissions is promising.

- Of 16 admissions to the Turning Point program, only two children have been admitted to an inpatient facility within 90 days after using the program. This represents a 12% readmission rate.
- Of 11 crisis responses that resulted in work with the family rather than an admission to Turning Point, only three have been admitted to an inpatient facility within 90 days after using the program. This represents a 27% readmission rate.

In comparison, youth who were admitted to an inpatient facility instead of initially utilizing this program show a 40% readmission rate. In addition, while most inpatient admissions result in a breakdown of the foster care placement, only four youth who utilized this program experienced a placement change following the Turning Point intervention.

Since the program is part of STAR Health, it targets only children who are in the conservatorship of the State of Texas. However, the program could be equally effective for children living at home and for children with developmental or intellectual disabilities who have challenging behaviors.



The World with Comprehensive LCC

Comprehensive LCC not only improves effectiveness and efficiency of the service system, it improves quality of life. Michelle, Jimmy, and Bethany are three of the fortunate children whose communities embraced one of the promising approaches to LCC.

Michelle's story, continued ...

Michelle's life changed when a Bexar CARES worker engaged her family and helped them navigate and access multiple community resources to begin meeting the family's needs and instilling hope that change could happen for this family. A Family Partner (peer support specialist) helped the family access transportation to participate in services. Other providers came to the home and provided home-based support services, including counseling, mentoring, and tutoring. All of this was accomplished by multiple agencies with a single set of assessments and agency consents, organized by Bexar CARES, providing the family with one doorway to wrap around support services.

As a result, Michelle's family re-engaged in previously abandoned counseling and received medical care for chronic conditions. Now Michelle is back in school, as are all of her siblings. There is improved communication with schools, the children's grades are improving, school attendance is no longer an issue, and the family is following through on counseling suggestions and appointments. Michelle is once again living with her mother and siblings.

Jimmy's story, continued ...

Jimmy's life changed when he was referred to the START team. At the beginning, the family expressed doubts that they could continue to manage the situation. Since working with the START team, he has been diagnosed and successfully treated for obsessive-compulsive and bipolar disorders, and his behavior has improved dramatically. He continues to receive support staffing through a provider agency in the family home, and members of the START team provide ongoing training and support to his direct service staff. A START clinician attends Jimmy's psychiatric appointments to assist in communicating with his psychiatrist, and talks with his other providers to ensure that everyone on his team is in communication with regard to Jimmy and his mental health care needs. While Jimmy continues to have ongoing challenges, he and his family are no longer in constant distress. The system is linked, communication is active, and everyone continues to benefit from this approach – especially Jimmy.



Bethany's story, continued ...

Bethany's life changed when Bexar CARES intervened to help her return home and prevent the removal of Bethany and her siblings in the future. CPS and Bexar CARES mental health professionals have daily contact with the family via telephone calls or home visits. Social service staff helped the family acquire new beds for the children, storage bins for clothing, and even a functioning washing machine. A counselor works with Bethany and her mother to improve their relationship and communication, and now they make a game out of doing laundry together. Bethany received reading intervention at school, and a case manager worked with the family, training the mother in ways to be a more effective parent and enhance her parenting and organizational skills. As a result, Bethany is doing better in school, the house is cleaner, and Bethany and her brother have clean clothes. Their mother works with a Family Partner to discuss concerns as they arise. This family continues to require advocacy, supports, and encouragement, but is making good progress.

Cost Effectiveness of LCC: START

The following table provides data for START services in Tennessee and demonstrates that for this comparatively small sample, the average costs for clients with START services were much less than the costs for clients receiving other service options.

Comparison of Average Emergency Service Usage and Associated Costs of Clients with and Clients without Tennessee-START Services (N = 10) ⁸				
Emergency Service	TN-START Clients		Non-TN-START Clients	
	Average Number per Client	Average Cost	Average Number per Client	Average Cost
Emergency room visits	0.47	\$39.34*	5.2	\$435.24
Psychiatric hospitalizations	0.67		2.6	
Days in hospital	7.3	\$4,403.21	19.93	\$12,021.38
Crisis contacts	(TN-START crisis) 2.7		(Community-based mobile crisis) 2.7	
Police contacts	0.67		4.13	
Respite days	7.6	\$3,274.00	32.2	\$15,778.00

⁸ Source of data: 5/10/12 Webinar sponsored by the National Association for Persons with Developmental Disabilities, presented by Joan B. Beasley, Center for START Services, Institute on Disability, UCED, University of New Hampshire.

The START program implemented in North Carolina has also experienced cost savings during the first year of implementation. The average *annual* cost per individual supported by North Carolina START was \$6,674. In comparison, a conservative cost estimate of a *seven-day stay* in a state psychiatric hospital is \$10,000.

Cost Effectiveness of LCC: Bexar CARES

According to the 2010 Legislative Report on HB 1232, there is potential for significant return on investment if the Bexar CARES strategies are implemented. The project estimates the return on investment to be in the range of \$6,000 to \$8,000 per family through:

- More effective use of staff time spent on cases through interagency coordination
- Child placement in traditional school settings instead of alternative settings
- Reduction of referrals and prevention of more extensive involvement in child welfare systems
- Expedited and coordinated referrals between systems, maximizing existing resources
- Parents not experiencing lost wages as a result of the need to attend multiple appointments

The Bexar CARES pilot has demonstrated that many costs can be avoided by early uniform screening, expedited referral and intervention, and multisystemic coordination that includes children and families.



LCC Strategic Recommendation

The recommendation for LCC is designed to help the State establish a new kind of relationship with local communities by partnering differently with them. The goal is to empower local communities to create and own initiatives that meet the needs of families in the community, a paradigm shift on the part of the State toward a community development model whereby the State supports local leadership.

Communities would conduct a needs assessment, identify gaps, and submit a plan to develop a CPI system. Development of a CPI plan would require an identified entity to take the lead in pulling together a broad range of community stakeholders – for example, representatives from local and state agencies, parents, caregivers, educators, and first responders.

The State would partner with the local entity that assumes leadership of the CPI plan and support the community partner by providing:

- Designated staff to offer technical assistance and support
- Funding to help the community evaluate, plan, coordinate, develop, and enhance resources to increase the number of children and families receiving supports and services that prevent and respond effectively to crises

Instead of responding to crises in a disjointed manner through expensive reactive interventions, Texas communities utilizing this approach could more effectively organize and mobilize resources to reduce the number of families that experience crises due to insufficient and/or ineffective interventions or lack of coordination and planning of interventions and services.

Vision Statement

Communities are able to effectively create, mobilize, and sustain resources to prevent crises for children with special needs and their families and to respond immediately when a crisis occurs.



LCC Core Recommendation

To facilitate the development of comprehensive CPI systems across Texas, the State should:

1. Designate staff (by repurposing existing staff, hiring new staff, or outsourcing the responsibility to a contractor) who operate under a community-capacity-building approach to provide technical assistance and support that:
 - Facilitates distribution of such funds as may be available to develop and implement community-based CPI plans
 - Actively engages communities
 - Identifies community champions
 - Provides information about evidence-based and promising practices
 - Provides tools and assistance for assessment and evaluation
 - Helps remove barriers at the state level that prevent families and children with special needs from accessing necessary services and supports for CPI
 - Monitors and participates in evaluating community progress toward execution of a CPI plan
2. Provide funding which is contingent on an acceptable plan with community-identified performance benchmarks. Some communities will be able to incorporate all 12 elements, identified below, to fully achieve a robust CPI plan; others may need to identify a few key elements as initial goals, with subsequent efforts to put all the elements in place.
3. Partner with a community entity, such as:
 - A local mental health authority or local authority for intellectual and developmental disabilities)
 - A CRCC
 - Community coalitions
 - A nonprofit organization
 - A faith-based organization

to assume leadership and support the community in the development of a CPI plan, based on a community assessment and identified needs, that addresses the development of the following elements:

- Formal and informal community networks and relationships that link resources
- Interdisciplinary teams with the capacity to conduct clinical assessments
- Mobile crisis teams with the capacity to effectively respond to a crisis situation involving a child with special needs
- Capacity for formal and informal respite, including scheduled, therapeutic, and crisis respite, offered by competent providers
- Expedited services for emergency and urgent needs
- Child mental health and trauma screening using a common assessment instrument



- Whole-family screening to assess the need for additional social services – for example, behavioral health assessment of siblings – using a common assessment instrument
- Electronic cross-system information exchange of consents, demographic data, and screening and assessment results so that multiple state agencies can access information about the same child and family
- Cross-system training for clinicians, service providers, first responders, and families
- Evidence-based or promising practice peer support for families
- Ongoing community cross-system evaluation of CPI
- Local sustainability plan



Improving LCC for CPI: Current Status and Opportunities

Many of the elements of effective LCC are familiar to the Task Force agencies. Several of the agencies implement one or more of these elements in their current service array. However, the proposed model is different because it is driven by the local community, with the State serving as a supporting partner to help the community coordinate, develop, and enhance resources to increase the number of children and families that receive supports and services that prevent and respond effectively to crises. The following are highlights of current agency status and future opportunities; more information is available in Appendix E.

Health and Human Services Commission (HHSC)

CRCGs, if implemented as originally intended and expanded to address crisis prevention and gaps in the system, approximate what the subcommittee is recommending. However, when state-level support for CRCGs was reduced and funds were suspended, the benefits of these groups decreased dramatically. If funded, HHSC could reinstate and redirect the state-level support necessary to help communities to assess and build local capacity, and to share experience with using resources differently and with using evidence-based practices that are effective in coordinating needed services for children with special needs and their families.

Department of State Health Services (DSHS)

Within DSHS, both the MHSA Division and the FCHS Division have long-standing engagement with historical LCC activities, particularly through CRCGs. The divisions have supported and continue to support development of memoranda of understanding and memoranda of agreement, and incentivizing communities to develop and implement programs that improve the health and well-being of children with special needs and their families.

Both divisions have the capacity to conduct clinical assessments; however, through LMHAs, MHSA has greater expertise with and capacity related to behavioral health services, including deployment of mobile crisis outreach teams, expedited emergency and crisis services, and child mental health and trauma screening. MHSA, and FCHS through its Children with Special Health Care Needs Services Program, both provide access to respite services, though due to eligibility criteria and other program guidelines, such services currently may be limited in scope and duration. DSHS/MHSA has initiated cross-system training in partnership with DFPS and soon will fund training for providers and collaborative partners, including DFPS, TEA, and TJJD.



Programs in both divisions actively engage families and peers as partners in various ways, and the divisions have staff members and stakeholders who can participate in exploring further development of additional LCC efforts, including cross-system information consents and data exchanges; community-based interdisciplinary teams with the capacity to conduct clinical assessments and make referrals to appropriate public or private community mental health service providers; and cross-system evaluation of CPI.

Department of Family and Protective Services (DFPS)

DFPS is active in community engagement; however, not all agencies are at the table at the same time. Therefore, collaboration to assist families is not maximized. Improved agency coordination facilitates communication and thus offers families services targeted specifically to their needs, as opposed to more generic services offered to everyone.

This recommendation is compatible with *alternative response*. Alternative response (AR) is a shift in how CPS responds to certain cases of alleged abuse and neglect while still keeping children safe. It allows workers to engage families and refer to other community supports to ensure child safety.

LCC will offer better collaboration around services to enhance child safety, permanency, and well-being, especially for children with special needs. CPS could also help inform the local community network whenever a family with a special needs child has come into contact with us due to a lack of services.

Texas Education Agency (TEA)

TEA supports LCC for crisis prevention and intervention through support of local independent school districts, regional ESCs, and representation and coordination with various local agencies and councils. These entities already receive grant money from TEA for activities aligned with the LCC recommendation, so implementing the recommendation need not result in a fiscal impact on public education or on TEA itself. Finally, TEA's leadership is committed to encouraging and supporting local efforts to provide resources for families and schools of children with special needs through awareness building and public recognition.

Department of Aging and Disability Services (DADS)

DADS supports LCC by participating in and facilitating a variety of programs and projects that involve stakeholders, including individuals, family members, service providers, and advocates, across Texas at local levels, such as IDD local authorities for individuals with intellectual and developmental disabilities, Take Time Texas, Aging and Disability Resource Centers, the Autism Council, CRCGs, and the Promoting Independence Advisory Committee.



Enterprise-wide collaboration, coordination, and information sharing (across all health and human services agencies) would ensure more comprehensive, timelier, and higher quality service delivery. For example, increased collaboration and communication with DSHS at the local authority level would help to minimize duplication, serve individuals more effectively in the community, and raise awareness about the special needs of individuals, including children with multiple disabilities. Some local authorities are making efforts to bridge these gaps. Currently, through a Medicaid 1115 waiver, local authorities are being afforded the opportunity to establish pilot projects, many of which will increase LCC. Some of the projects include START. Depending on the success of some of these projects, specifically the START projects, DADS could encourage or incentivize other local authorities or community organizations to build their own teams locally. DADS is committed to continuing to support these efforts.

Finally, DADS could continue to strengthen partnerships with local law enforcement agencies, fire departments, and other first responder organizations for training opportunities and to identify areas of improvement for state involvement at a local level. It is DADS's mission to provide a comprehensive array of aging and disability services, supports, and opportunities that are easily accessed in local communities.



Potential Source of Funding

Although it is beyond the scope of the subcommittee to identify sources of funding, one possible source came to the group's attention and merits further study. The subcommittee recommends that the State consider:

Redirecting a percentage of the managed care experience rebate toward the implementation of crisis prevention efforts.

Experience Rebate

The experience rebate is the portion of an MCO's net income before taxes that is returned to the State in accordance with the HHSC Medicaid Managed Care and CHIP contracts.

At the end of each financial statistical reporting period, the MCO must pay an experience rebate if its net income before taxes is greater than a set percentage of the total revenue for the period. The experience rebate is calculated in accordance with the graduated experience rebate method presented in the table below.

Pre-tax Income as a % of Revenues	MCO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

In fiscal years 2011, 2012, and 2013, the State collected \$26.8 million, \$51 million, and \$24.2 million, respectively, in experience rebates. In fiscal year 2013, if 1% of the experience rebate were redirected to CPI initiatives, \$242,000 would be available for crisis prevention initiatives. A 5% redirect would provide \$1,210,000.

S.B. 1, 83rd Legislature, Regular Session 2013, Article II, Rider 13 includes managed care rebates in the definition of Medicaid program income. The rider clarifies that HHSC is authorized to receive and spend income from experience rebates, but it must use income from the rebates to fund services for Medicaid clients.

If the state incentivized or required MCOs to implement crisis prevention programs, any cost savings achieved would result in a greater experience rebate. If the dollar amount of rebates collected by the state increases by at least the percentage of any redirected funds, this recommendation would be cost neutral. A more detailed cost analysis should be performed by HHSC financial experts to confirm the likelihood that this goal could be achieved. If the Task Force chooses to move forward with this recommendation for the purposes of funding crisis prevention activities that are outside the scope of services for Medicaid clients, legislation would be necessary to allow the use of these funds for such purposes through the General Appropriations Act.



Next Steps

The subcommittee gratefully acknowledges the additional time the Task Force gave the group to continue to work together beyond August. This extension gave the subcommittee time to fully explore the complex issues related to PBS and LCC and to develop overarching recommendations for both tactics.

This report includes a table of concrete implementation options for PBS. The subcommittee would like to develop a parallel table of implementation options for LCC to make it easier to understand what the subcommittee envisioned when crafting the recommendation. As with PBS, this additional level of detail would serve as an important guide for those tasked with future implementation.

With three more meetings, the subcommittee could take advantage of the extensive knowledge members have developed to complete an addendum to this report with concrete implementation options for LCC. A proposed meeting plan is presented in the table below.

Prior to Meeting 1	High-level background research about implementing the LCC recommendation
Meeting 1	Generate and categorize ideas
Between meetings	Internal research to get agency feedback and identify missing components
Meeting 2	Refine table on the basis of agency feedback
Meeting 3	Finalize table

The subcommittee believes detailed scrutiny of the remaining 12 of the 14 originally identified tactics would best move the State toward preventing crises and ensuring appropriate and timely crisis response. The group devoted their energy to PBS and LCC because members believe implementing recommendations related to these two tactics could have the greatest impact. The following topics emerged with particular importance, and any one of them would be a natural place to begin future planning efforts.

- **Family resource specialist/comprehensive case manager/support coordinator.** Families could benefit greatly from access to a competent individual manager without ties to specific programs or conflict of interest to help them work through the system. This person should be knowledgeable about available local and state resources and services, be assigned to a child and family, and operate from a person-centered rather than a program-focused perspective. This idea would require a redesign of the case management function, possibly with blended funding, to avoid multiple case managers operating in separate spheres.



- **Peer support.** In families with children with special needs, there is a critical need for a person with a similar experience to connect with the family. This person’s role is to talk with and listen to the family, share experiences, facilitate, and help the child and family work through the system. Ways to compensate nonprofessionals in this role should be explored. The in-home support research brief in Appendix G includes information about networks to support parents and families.
- **Respite.** The subcommittee learned from research and presentations that the state is already doing much to increase access to respite. However, the need is still huge and appears to be unmet in many communities. The subcommittee discovered that there is no mechanism to effectively measure the extent of the need for respite for children with challenging behaviors. Access to three types of respite (scheduled, therapeutic, and crisis) offered by competent providers would make a remarkable difference in quality of life for children with special needs and their families, and would go a long way toward preventing crises. (Appendix F includes research on respite.)
- **Training.** The need for training came up in multiple contexts, for example:
 - Training professionals for implementation of PBS
 - Training for families and other caregivers in person-centered practices, PBS, and how to build networks around the family (Appendix B includes information about person-centered practices and building networks.)
 - Training for first responders, healthcare professionals, law enforcement officials (including school resource officers), and others who come in contact with children with special needs, and whose actions could diffuse a situation or escalate it into a crisis
 - Training for community entities to help them better evaluate, plan, and coordinate resources and services
- **Workforce development.** Implementing the PBS recommendations will require developing a workforce that is knowledgeable of the principles and skilled in the practice of PBS. Discussions about respite and in-home supports highlighted the need to increase the number of the members of the direct care workforce and improve their skill sets.

The subcommittee anticipates that long-term cost savings would result from implementing the PBS and LCC recommendations, which could be redirected to be more effective. Addressing challenging behaviors early through PBS is likely to decrease the need for more expensive interventions such as emergency room visits, hospitalization, and/or incarceration. Helping local communities maximize their own resources and increase capacity to prevent crises could save money that would otherwise be spent on more intensive interventions responding to crises. However, implementation of the PBS and LCC recommendations will require an investment on the part of the State to catalyze systems change.

Subcommittee Process

The initial planning work of the subcommittee began in November 2012, and a formalized structure was put in place in March 2013. SUMA Social Marketing, Inc., (SUMA) was contracted to provide a support system that would allow the subcommittee to accomplish its task and maximize the use of its time. Services provided through the support system included assistance in identifying, researching, and evaluating best practices and programs in crisis prevention and intervention; organizing, preparing, and presenting summary research documents to inform discussions; facilitation of subcommittee meetings; and assistance in the preparation of a cohesive and detailed plan with recommendations.

The subcommittee met on the first and third Fridays of every month. Through May, it met from 11:30 a.m. to 1:30 p.m. Once the regular session of the Legislature ended, the subcommittee extended its meeting time to three hours, from 11:00 a.m. to 2:00 p.m. (Appendix A includes the notes of every meeting.) The subcommittee added a third meeting in November and December to ensure a quality report.



The process that the subcommittee implemented to gain a full understanding of the first tactic, PBS, and to develop recommendations is detailed below. This process was also used to develop informed recommendations for LCC, the second topic the group addressed.

- Read the SUMA research brief and explore the links provided in it. (Appendix B includes PBS research materials; Appendix D includes LCC research.)
- Tap the knowledge and expertise of subcommittee members through informal presentations and discussion.
- Answer any remaining questions through additional written research from SUMA, outside speakers, and conference calls with experts in Texas and other states (during or between meetings).
- Develop a vision statement specific to the tactic under discussion (initial draft with full subcommittee during meetings, refinement by a small group working between meetings).
- Draft recommendations.
- Condense and refine recommendations (small group working between meetings, full subcommittee working during meetings).
- Finalize the recommendations using feedback from the subcommittee's executive sponsor (SUMA drafts between meetings, subcommittee reviews and approves during meeting).
- In consultation with the agency representative on the Task Force, write a short description of how the recommendations dovetail with and/or affect the agency's current situation, and of the level of support required to implement the recommendations. (This task falls to the subcommittee members who represent the respective participating state agencies.)
- After the subcommittee agrees on the vision, definition, and recommendation, work with SUMA to draft the report.
- Revise the report as many times as necessary to meet the standard for consensus (each person on the subcommittee feels at least an 80 percent comfort level with the language).

The subcommittee intended to explore all 14 tactics that members identified early in the process. The group worked as quickly and efficiently as possible through highly productive meetings and additional tasks accomplished between meetings. However, it became apparent that several meetings were required to learn about a topic, several more to understand the cross-agency implications and develop recommendations, and several more meetings per topic to reach consensus on the language for the report describing the context for the recommendations.

