CHECKLIST OF OUTCOMES, PERFORMANCE EXPECTATIONS & RECOMMENDED GUIDELINES FOR:

THE COUNTY CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP) & CASSP COORDINATOR POSITION

COUNTY CASSP INDICATORS

Administration at the county level should ensure that the system infrastructure is in place to implement and manage a comprehensive system of care as indicated by the following CASSP related activities:

C = current practice and/or County CASSP standard
G = goal to be attained, currently in process
R = item rejected or not applicable to local CASSP operations

#	C	G	R	COUNTY CASSP PERFORMANCE INDICATOR
1				Maintaining a local full-time administrative CASSP Coordinator position that functions in the county to serve as a focal point for establishing and maintaining a network, and building on an existing network of individuals, agencies, providers, and community groups interested in improving services to children, adolescents, and their families.
2				Ensuring that the identity and role of the CASSP Coordinator is known by child/adolescent-serving system staff and provider staff and this information is easily accessible to families and other community members.
3				Developing an integrated system of care through the creation of interagency agreements or maintaining and improving existing ones between target systems, including Child Welfare, Mental Health, Mental Retardation, Education, Juvenile Justice, Drug and Alcohol, Vocational Rehabilitation, providers, family groups and other child/adolescent related community-based resources.
4				Organizing and staffing a local clinical/case management level interagency committee(s) responsible for collaboration, case review and problem solving for children and adolescents with serious emotional disturbance and/or substance use disorders with multi-system needs.
5				Creating and/or maintaining a community advisory committee, representative of the population being served, with culturally diverse representation from families, providers, advocates, system representatives, county administration, and interested groups. This advisory committee should meet for regular discussion of child and adolescent issues and cross-system collaboration that may include behavioral health and other cross-system concerns, and needed changes in local policies and procedures that affect children/adolescents and families. This committee should also review the progress of the local CASSP project and develop or recommend strategies for meeting local goals and objectives.
6				Collating and updating local needs assessment information to include gaps, duplication, and barriers to service and developing a planning strategy for meeting the

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				needs. The planning strategy should include identification of training, especially cross-system training and technical assistance needs
7				Utilizing advocate and constituent groups, establish family supports for families of children/adolescents with serious emotional disturbance or substance use disorders.
8				Ensuring that families, utilizing advocate and constituent groups, are included as a system partner in county-based planning and decision-making.
8a				Encouraging involvement of providers in county-based planning.
9				Using the "Indicators of the Application of CASSP Principles" as part of the county planning process, examine the CASSP project including the child/adolescent-serving system procedures, practices, and outcomes to ensure that CASSP Principles are implemented throughout the child-serving system.
10				Ensuring that providers serving children/adolescents in multi-systems incorporate CASSP Principles in existing services and in the development of new services.
11				Developing or maintaining a shared funding base for the County CASSP position/function and initiatives for future years. (Example: funds from Mental Health, Mental Retardation, Education, Juvenile Justice, Child Welfare, Drug and Alcohol, Human Services Development Fund, etc.)
12				Resolving a system-specific or child/adolescent-specific issue by integrating the philosophies, or assisting a specific child/adolescent and family by addressing stalemates in treatment, funding, and/or access to quality services.
13				Identifying goals and implementing strategies that ensure services are culturally competent for all populations in the child/adolescent-serving systems.
14				Employing as a family consultant(s), a family member(s) of a child/adolescent who is currently being served or who has been served in a child/adolescent-serving system. The family consultant(s) ensures family involvement at all levels by assisting and advocating for the needs of children/adolescents and their families to be appropriately met by the child/adolescent-serving systems including direct links to the family/youth satisfaction teams.

CASSP COORDINATOR POSITION

The general purview of an individual CASSP Coordinator can be separated into three defined areas: child/adolescent and family related; multi-system related; and skills related.

CASSP COORDINATOR POSITION: CHILD/ADOLESCENT & FAMILY RELATED DUTIES

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#	C	G	R	CHILD/ADOLESCENT & FAMILY RELATED DUTIES
15				Provides leadership and role modeling for advocacy
16				Engages parents/families in the child/adolescent-serving system as equal partners in treatment plan development, on advisory committees, in program development, program review, etc.
17				Ensures that interaction with parents/families is viewed as an equal partnership when serving an individual child/adolescent and his/her family.
18				Demands that respect for family members and their culture is maintained, and that their input and concerns are heard, documented, valued, and incorporated in the decision making process.
19				Ensures and documents that new program development takes into consideration needs identified by families and the design is supported by families.
20				Is knowledgeable of community resources, services, and support. Encourages and promotes the development of community resources, services and supports.

MULTI-SYSTEM RELATED DUTIES

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21				Links families and the individual youth to available community resources.
22				Facilitates the ongoing implementation and effectiveness of the child/adolescent-serving system and makes recommendations for and facilitates more effective collaboration.

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23				Facilitates ongoing assessment of child/adolescent system needs, including annual utilization of the "Indicators of the Application of CASSP Principles for County Mental Health Programs" (CASSP Indicators) • Identifies gaps in the service delivery system and makes recommendations for new services and programs • Facilitates making change, ensuring the partnership of families and other agencies in the process
24				Monitors child/adolescent services and programs for appropriateness, best practice and effective outcomes • Includes and is responsive to child/adolescent and family input about programs • Promotes appropriate implementation and utilization of the interagency process
25				Is a resource and provides technical assistance for the child/adolescent-serving agencies, families, school districts, and providers, i.e. is the "expert" on children and adolescent treatment and service needs in the county including funding, other community resources, and addressing child/adolescent stalemates in access, treatment, and coordination.
26				Participates, when possible, in multi-system collaboratives such as the local Transition Coordinating Council (TCC), Family Service System Reform (FSSR), Student Assistance Program (SAP) County Coordination, or local Early Intervention Interagency Coordinating Council (ICC).
27				Maintains objectivity across systems and adherence to CASSP Principles when collaborating within child/adolescent system.
28				Provides technical assistance to child/adolescent-serving entities so that actions and plans are driven by the needs, goals, and vision of the child/adolescent and family.
29				Points out issues of conflict or bias when they become apparent or are raised by the child/adolescent or family and moves toward resolution of same.
30				Practices and promotes conflict resolution skills and helps create a collaborative approach among child/adolescent-serving partners.
31				Participates in the local CASSP Advisory Committee and, as necessary, convenes, co-chairs/co-facilitates with a family member, ensures membership, and/or monitors the committee's functioning. In addition, the CASSP Coordinator ensures that the Advisory Committee adopts rules for governance that promote inclusion, consider all perspectives, and protect each member, including assuring the right to confidentiality to allow candid, safe, open discussion.

CASSP COORDINATOR POSITION: RELATED SKILLS

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#	C	G	R	RELATED SKILLS
32				Has a working knowledge of all the child/adolescent-serving system's structure and functioning, including: • methods and points of entry • assessment and evaluation process • each system's governing principles and philosophies and how they relate to CASSP principles • each system's laws, regulations, policies, funding, and local practices • the child/adolescent and family's legal rights under each system • methods of resolving conflict within each system
33				Possesses administrative skills, such as delegating, networking for ongoing technical assistance, collaboration, support, and tapping in to additional resources, both formal and informal.
34				Stays current on the treatment trends and best practice through workshops, seminars, conferences, networking, personal study and contacts

CASSP ADVISORY COMMITTEES

CASSP ADVISORY COMMITTEE STRUCTURE

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#	C	G	R	CASSP ADVISORY COMMITTEE STRUCTURE
35				The CASSP Advisory Committee is a safe forum for open discussion.
36				Participants of the committee are: • Family members of children/adolescents currently receiving services by two or more child/adolescent-serving systems, and adolescents who are, or have been, served in this system • Representatives of all child/adolescent-serving system entities, including but not limited to public agencies, providers, school districts, intermediate units, community and parent/family advocacy organizations, and other constituency groups

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#	C	G	R	CASSP ADVISORY COMMITTEE STRUCTURE
				• Representative of community's cultural diversity
				CORE CHARACTERISTICS
37				• Recognized organizational structure with regular meetings, planned agendas, and expected attendance • Shared ownership and responsibility for outcomes and implementation of policies and best practice standards • Realistic mechanisms to ensure full family involvement including: o Meeting times and places that are convenient for families. o Reimbursement for costs to attend meetings
				ADVISORY COMMITTEE FUNCTIONS
38				Promotion of collaboration within the child/adolescent-serving systems recognizing the CASSP Principles.
39				Modeling of effective cross-system collaboration and consensus building including partnership with families as an integral component.
40				Ensuring family participation/adolescent participation in system-wide as well as individual activities.
41				Ensuring awareness of issues across child/adolescent-serving systems, including review and analysis of pertinent data.
42				Identification and recommendation of resolutions for systemic problems and issues.
43				Identification of service gaps and program development needs across child/adolescent-serving systems.
44				Identification of systems' training needs and development of planning strategies to address them.
45				Promotion of self-assessment by system participants individually and as a system.
46				Assessment of the effectiveness of the committee's functioning.
47				Tracking progress of committee recommendations.

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48				Documentation and dissemination of information regarding committee activities.

FAMILY/YOUTH SATISFACTION TEAMS

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#	C	G	R	FAMILY/YOUTH SATISFACTION TEAM
49				Each county ensures a Family/Youth Satisfaction Team exists to determine whether children with serious emotional disturbance and/or substance use disorders and their families are satisfied with services and to help ensure that problems related to service access, delivery, and outcome are identified and resolved in a timely manner within the confines of confidentiality regulations.
50				The above goals are accomplished by gathering information through face-to-face discussions with child and adolescent recipients of behavioral health services and their families.
51				The county ensures that problems identified are systematically and systemically addressed in a timely manner and that data obtained is used for system improvement.
52				Family/Youth Satisfaction Teams are comprised exclusively of: o Family members of children and adolescents with serious emotional disturbance and/or substance use disorders who are receiving or have received behavioral health services in the publicly funded system o Child/adolescent recipients who are receiving or have received behavioral health services in the publicly funded system. o Older adolescents and/or young adults who are receiving or have received behavioral health services as a child or adolescent in the publicly funded system.
53				Family/Youth Satisfaction Teams are to be supervised by a person with expertise in the child/adolescent-serving systems and CASSP Principles.
54				An annual survey of families indicates that families perceive themselves to be respected as the primary caretakers for their children/adolescents, are treated as resources, and are included in decision-making about their child/adolescent. The annual survey will include no less than forty percent of the families served.

OUTCOMES

COUNTY CASSP OUTCOMES

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55				Parent/family advocacy organizations and other constituency groups are routinely included in all cross-systems activities and are included in any reference to 'intersystem'.
56				CASSP Coordinator position is filled.
57				CASSP Coordinator has a Master's Degree in a human service field or a minimum of five years experience in one or more child/adolescent-serving systems.
58				CASSP Coordinator is a discrete administrative position that has systems' acknowledged administrative responsibility and accountability for children/adolescents' services and for ensuring implementation of the CASSP Principles throughout the child/adolescent-serving system.
59				CASSP Coordinator provides no direct care services other than those special duties that may, from time to time, be required.
60				County ensures that CASSP Coordinator completes the statewide CASSP Coordinators Orientation.
61				County ensures that the CASSP Coordinator regularly attends OMHSAS sponsored and other relevant trainings, forums, and conferences.
62				County utilizes mechanisms for active oversight of child/adolescent-specific practices including quality of evaluations, interagency team meetings, service plans, treatment outcomes and specific service decisions to ensure that they are appropriate to the actual needs and culture of child/adolescent and family.
63				County ensures regular joint meetings of the local child/adolescent-serving system directors, Behavioral Health Managed Care Organizations (BH-MCOs) where applicable, and CASSP Coordinator with periodic inclusion of county commissioners or designees.
64				The CASSP Advisory Committee meets at least quarterly.

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65				County ensures coordination among providers, BH-MCOs where applicable, child/adolescent-serving systems, and CASSP Coordinator.
66				County ensures fully functioning and integrated CASSP Coordinator position under HealthChoices.
67				County ensures a mailing list is established and regularly updated to disseminate information related to the CASSP Project. • The list includes system professionals, parent/family advocacy organizations, cultural groups, community agencies, churches, and other relevant community leaders and constituency groups.
68				County ensures that orientation to CASSP Principles occurs for all relevant staff in the child/adolescent-serving systems and provider agencies.
69				All staff in the child/adolescent-serving systems are able to consistently demonstrate their ability to operationalize CASSP Principles as measured through annual review of the CASSP Indicators and Family Satisfaction Surveys by the CASSP Advisory Committees.
70				Families, intersystem professionals, members of the CASSP Advisory Committee, community advocacy organizations, cultural groups, and other interested community members have opportunities for input into all county child/adolescent serving system plans.
71				Cross-system training and relationship building occur routinely. Examples include cross-system training days, CASSP luncheons, cross-system children's fairs, award banquets, and agencies routinely inviting other system staff and families to scheduled training with family involvement in planning and program participation.
72				Intersystem conflict resolution processes are established and included in letters of agreement between the child/adolescent-serving systems. The CASSP Advisory Committee reviews, at least annually, the adequacy of the processes and makes recommendations for revision to appropriate child/adolescent-serving system administrators.
73				An intersystem forum to develop/review treatment/service plans for individual children/adolescents needing multi-system support exists and meets as needed with all currently involved and/or appropriate child/adolescent-serving systems and family members participating with the appropriate informed voluntary consents to disclose information signed. For alleged or adjudicated delinquent or dependent

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				children/adolescents, the requirements of Act 126 shall apply.
74				Each child/adolescent-serving system and their providers offer written clarification, distribution, and regular public posting of the process for individual problem resolution within each county.
75				Child/adolescent-serving system directors and the CASSP Advisory Committee have input into the CASSP project's evaluation and documentation is available that there is consensus among relevant groups, i.e. the CASSP Advisory Committee, public agency directors, and parent groups that the local CASSP project is addressing their concerns.
76				Mechanisms exist to implement shared funding for individualized service responses for children/adolescents when appropriate.

FAMILY & PROFESSIONAL COLLABORATION OUTCOMES

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77				Family-led support group(s) meet regularly.
78				Family representatives participate in child/adolescent-serving system planning meetings.
79				A family/professional co-chair model for the CASSP Advisory Committee has been adopted.
80				Informal Family Advocacy Group/Provider dialogues occur regularly.
81				Families attend their child/adolescent's treatment/service plan meetings and every effort is made to accommodate family schedules and identified extraordinary needs.
82				Families actively participate in their child/adolescent's treatment/service plan meetings with encouragement and support from the child/adolescent-serving systems.
				Families and involved parties are provided with a written meeting summary with

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83				identification of responsible parties for each task with timeframes and contact information.
84				All persons who agree to complete tasks outlined in the plan do so within the expected timeframes. This includes agencies, providers, parents, family members, the child/adolescent and advocates.
85				Provider agencies offer families information and resource material that clearly explains diagnosis, treatment, coping skills, collaboration, and advocacy and are available to review and discuss the information.
86				Families are provided with copies of child and family rights from each involved system, including complaint and grievance procedures.
87				Families are referred to appropriate local, state and national advocacy resources including child advocacy groups/organizations.
88				Families provide training to child/adolescent-serving systems and provider staff on the family perspective, family engagement, and partnering with families as essential elements of orientation and ongoing training events.
89				Families are invited to attend and encouraged to actively participate in provider and administrative training on children/adolescents' issues.
90				Families are supported in increasing their effectiveness to advocate for the child/adolescent through funding to attend local, state and national conferences. Costs covered may include registration, lodging, transportation, meals, child care, and/or other related expenses.
91				When families provide training they are paid an honorarium equal to that of other trainers.
92				Proposals submitted to state offices for new service initiatives include support letters from families and documentation that both the need for the program and the program design were established with family and advocacy input.

INTERSYSTEMS COORDINATION OUTCOMES

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93				The local ideal system of care for children/adolescents is established, with input from the CASSP Advisory Committee and any other interested parties, and is available as a document to any interested parties.
94				CASSP Coordinators and CASSP Advisory Committees provide input for Children and Youth, Education, Drug and Alcohol, Juvenile Probation, Mental Health, and Mental Retardation, annual plans that address local children/adolescents' service gaps and priorities.
95				CASSP Coordinators and CASSP Advisory Committees provide input for children/adolescents' service providers about specific program development viability and program adherence to each CASSP Principle.
96				Directors of Mental Health, Mental Retardation, Drug and Alcohol, Children and Youth, intermediate units, school districts, Juvenile Probation, and representatives of family advocacy projects and groups meet together at least quarterly together to discuss children/adolescents' issues. Representatives from Behavioral Health Managed Care Organizations, providers, and others are invited as appropriate.
97				Cross-system orientation and at a minimum annual training is used as one vehicle to transmit CASSP Principles and practices. Topics that should be covered include: eligibility criteria, overview of laws, regulations and mandates, point of entry, collaboration, confidentiality, and services offered.
98				An intersystem release of information procedure is established and integrated into staff orientations. Both interagency team meetings and higher level county CASSP meetings, when a specific family is involved, require an informed, voluntary, signed consent to disclose information; and orientation of the child/adolescent and family as to the purpose and procedures of the meeting.
99				Interagency service planning occurs regularly based on clinical need or request; children/adolescents' files/charts reflect intersystem contacts and task distribution.
100				Providers and/or child/adolescent-serving systems utilize interagency meetings to address issues and areas of concern in service delivery.

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101				Procedures are established to coordinate discharge planning and aftercare implementation for children and adolescents returning from out of home placements. These procedures include mechanisms to ensure partnership with the family in the provision and continuity of an appropriate level of care for the child/adolescent, including continued medical assistance (MA) eligibility, aftercare, psychotropic medication where indicated and establishment of "lead" or joint case management.
102				Each county tracks annually, reasons for residential placement (from Attachment 8 in the Medical Assistance Bulletins addressing residential treatment), reasons for placement more than two hours away but still in Pennsylvania, and reasons for out of state placement. Counties also track length of time prior to placement, length of time in placement, length of time to begin recommended community services after returning from placement. Information is reviewed by the County CASSP Advisory Committee and recommendations are considered for incorporation into the County Mental Health Plan.
103				The local Student Assistance Program coordinates with other child/adolescent-serving systems and incorporates the CASSP Principles in their policies, procedures, and activities.
104				Each of the major child/adolescent-serving systems agrees that the local CASSP project has addressed intersystem issues that affect their own target populations as measured by the CASSP Indicators. This includes family advocacy projects and groups, Mental Health, Mental Retardation, Child Welfare, Drug and Alcohol, Special Education, Education, Juvenile Justice, Vocational Rehabilitation, and any other systems local projects may have included (such as the County Assistance Office, Social Security, school districts, etc.).
105				Multi-system shared funding based on individualized service plans occurs routinely for children/adolescents.
106				Early Intervention issues and coordination have been addressed in collaboration with the local Early Intervention Interagency Coordinating Council.
107				The county has developed its own set of specific indicators of the effectiveness of interagency team meetings that is tracked annually.

CULTURAL COMPETENCE OUTCOMES

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108				All components of the child/adolescent-serving system strive to be culturally competent and are actively moving toward the reflection of the cultural diversity of the area and population being served consistent with the "Cultural Competence Recommended Standards: Clinical and Rehabilitation" developed by the OMHSAS Cultural Competency Advisory Committee.
109				Orientation and cross-systems training includes a component on cultural competence.
110				Each county system ensures that there is sufficient capacity of qualified culturally competent trainers to meet the training needs within the county.
111				Children/adolescent and family surveys have been developed and include the opportunity to comment on the cultural appropriateness of the service they received.
112				Preferences regarding culture and tradition are included as a routine part of interagency team meetings and included in treatment plans.
113				Assessment of the cultural diversity and competencies of local child-adolescent-serving staff and provider staff promotes the development of strategies to move toward a culturally competent system of care.
114				Local CASSP network mailing list includes but is not limited to religious leaders, faith-based groups, cultural centers, community health, family centers, and community organizations who represent the cultural diversity within the community.

SERVICE DEVELOPMENT OUTCOMES

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115				Results of needs assessments are made known to the community at large. All agencies, providers, and community organizations are encouraged and assisted to develop programs to meet identified needs.

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116				Mental Health, Mental Retardation and Drug and Alcohol Annual Plans address development of non-MA funded child/adolescent community based services.
117				County use of family support funds includes the availability of respite support for families of children at risk of psychiatric hospitalization or out of home placement.
118				The child/adolescent-service system, including providers and BH-MCOs, provides a comprehensive array of services consistent with CASSP Principles. In addition, new services are initiated or modified when a need is determined.
119				Creative funding solutions are obtained by county and providers for family and child/adolescent needs not currently funded including the use of reinvestment dollars in HealthChoices counties. Documentation of county-based efforts is available from the county Mental Health/Mental Retardation Administrator.
120				An array of support services for families of children /adolescents with a serious emotional disturbance and/or substance use disorders are available in the county.
121				Child/adolescent providers accommodate to family availability and obligations in scheduling services including the use of non-traditional hours such as weekends and evenings.
122				Easily accessible, 24-hour crisis intervention services including assessment, emergency intervention, and referral, as appropriate, are provided by mental health professionals whose training includes CASSP Principles and crisis intervention with children and adolescents. Drug and alcohol crisis services are also easily accessible and provided by drug and alcohol professionals.
123				Crisis mental health services for children and adolescents, including mobile and crisis residential services are available and accessible when clinically indicated.
124				Child/adolescent mental health resource and mental health and drug and alcohol intensive case management is available as needed in the county.
125				Quality assurance standards for children/adolescents that reflect CASSP Principles have been adopted by child/adolescent providers.
126				The mental health and drug and alcohol providers have clinical staff trained in family therapy, child/adolescent treatment modalities, and child/adolescent use issues.
127				Adequate and appropriate school-based services are available in the county.
				Adolescents participate in person, as considered appropriate, or via

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128				telecommunication in their interagency service plan meetings including youth in custody of Children and Youth or in a juvenile facility.
129				The children and adolescents in the juvenile justice system have access to appropriate mental health and drug and alcohol screening and adequate treatment.
130				Children/adolescents who have been diagnosed with co-occurring disorders receive appropriate treatment with the goal of moving toward an integrated system of care.
131				Consistency and coordination among treatment/service/educational goals and objectives is evident.
132				All children/adolescents who are MA eligible receive an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screen for an emotional or behavioral disorder, as well as physical conditions.
133				Children/adolescents in residential placements or hospitals are monitored regularly by the lead agency in partnership with the child/adolescent's family.
134				Targeted case management or close county oversight is routinely provided to children/adolescents in a Residential Treatment Facility (RTF).