CCAP Complex Case Work Group

Findings and Recommendations
February 2024

Work Group Members

Chair George Hartwick *Commissioner* | **Dauphin County**

Kevin Barnhardt *Chief Operating Officer* | **Berks County**

Bruce Erb *Commissioner* | **Blair County**

Pat Fabian *Commissioner* | **Armstrong County**

Jean Foschi *Commissioner* | **Cumberland County**

Sherene Hess *Commissioner* | **Indiana County**

Christine Sadler *Solicitor* | **Berks County**

Pam Tokar-Ickes *Commissioner* | **Somerset County**

Dan Vogler *Commissioner* | **Lawrence County**

Julie Wheeler *Commissioner* | **York County**

Pam Bell *Single County Authority Administrator* | **Delaware County**

Jewel Denne *Assistant Deputy Director of the Office of Behavioral Health* | **Allegheny County**

John DiMattio *Director of Human Services* | **Erie County**

Stacie Horvath *Human Services Administrator* | **Franklin County**

Kate Lowery *Single County Authority Administrator* | **Beaver County**

Marisa McClellan *Administrator* | **Dauphin County Social Services for Children and Youth**

Crystal Natan *Executive Director* | **Lancaster County Children and Youth Agency**

Brandon Savochka *Human Services Director/MHEIID Administrator* | **Butler County**

Staff

Lisa Schaefer *Executive Director* | **CCAP**

Michael Sage *Chief Operations and Information Officer* | **CCAP**

Melanie Gordon *Human Services and Criminal Justice Policy Director* | **CCAP**

Brian Bornman *Executive Director* | **PCYA**

Chrystal McCorkel *Affiliate Admin Associate* | **PCYA**

Michele Denk *Executive Director* | **PACDAA**

Thomas Stark *Executive Director* | **PACSHA**

Lucy Kitner *Executive Director* | **PACA MH/DS**

Deb Neifert *Deputy Director* | **PACA MH/DS**

Arwen Sniatecki *Affiliate Admin Associate* | **PACA MH/DS**

Acknowledgments

The Complex Case Work Group was privileged to have the participation of key stakeholders who shared their expertise with the members, and the work group wishes to acknowledge them for their contributions. Throughout the course of various work group and subcommittee meetings, the following individuals made presentations, provided background materials and research, engaged in discussions with staff, and shared information that has been utilized in the development of the work group report and recommendations.

Brinda Penyak ***Special Advisor to the Secretary*** | **PA DHS**
Jonathan McVey ***Complex Needs Planning*** | **PA DHS**
Nathan Humes ***Western Regional Director*** | **PA OCYF**
Tom Joseph ***Executive Director*** | **NACHSA**
Rachel Mackey Legislative ***Director for Human Services & Education*** | **NACo**
Heather Durosko | **COHSDA**
Terry L. Clark ***President and CEO*** | **PCCYFS**
David A. Mattern, ***MSW, Vice President Operations and Finance*** | **PCCYFS**
Mark Mortimer ***President and COO*** | **Adelphoi Village**
Morgan Berry ***Implementation Manager*** | **First Match**

Table of Contents

What are Complex Cases? 4

Current Landscape 5

Survey of Temporary Housing 5

Responsibility for Provision of Mental Health Services 6

Negative Outcomes for Children, Youth, and Staff 7

Process 8

Recommendations 9

Creation of no eject/no reject program 9

Development of additional programs 10

Collaborative cross-systems training 11

Regulatory and policy changes regarding funding 11

Use of Technology 14

Workforce 15

Resource Navigation System 16

Attachments 18

Executive Summary

Service Mapping Tool for Counties

What are complex cases?

The issue of "complex cases" involving children and youth in Pennsylvania has long been a problem for county mental health and child welfare departments. In recent years, this issue has been increasing, both in Pennsylvania and the majority of other U.S. states. While historically, a youth with complex needs may have required more time for county staff to locate a placement or treatment regime, recent years have seen many youth in the custody of the county sleeping in hotels and child welfare offices, regardless of the extensive efforts expended to locate appropriate treatment and/or placement.

A tremendous amount of time and effort is spent dealing with these cases, and the outcomes for these youth have been poor. The challenges in finding appropriate treatment lead to longer stays in care, greater challenges in returning home to their families, and challenges in finding placements later due to perceived negative behavioral issues when reviewing intake referrals.

The complex case issue has been recognized by many in the Commonwealth, leading to increased awareness and discussion regarding how best to address these challenges. The County Commissioners Association of Pennsylvania (CCAP) created a work group to look at these cases and to make recommendations on how best to address them. At the same time, the PA Department of Human Services (DHS) created the Complex Case Blueprint Workgroup. This DHS group included an array of stakeholders but seemed to be focused largely on root causes of cases where there are challenges obtaining appropriate treatment for youth in Pennsylvania, rather than immediate solutions that may alleviate the challenges in the near term.

While it is unlikely there will be a single set of recommendations with which all stakeholders can agree, there should be sufficient common ground upon which progress and some improvements may be made. One thing that all can agree on is that change is crucial, as many youths' immediate needs are not being met.

At the outset, it must be noted that there is no universal definition of a complex case; however, there are characteristics by which they are identified. A common denominator is that the youth need a mental or behavioral health service or placement that is not currently available. This could include delinquent youth for whom there is not an appropriate secure detention facility; it may mean youth who are still at home with their parents but need mental health services that are not currently available within the county or state. We note that other states may reference these cases as "high acuity" or "children without placements" (CWOP). Regardless of what they are called, these cases' key feature is that a person's needs are not able to be met with the current array and availability of services. This may be the result of a lack of such service or insufficient space in programs able to provide such treatment.

While recognizing that the following terminology will not meet with universal acceptance, we must start somewhere. As such, for purposes of this work group, we are defining "complex cases" as the following:

Minors who are in the custody of the county for whom there is not a level of care sufficient to meet their mental, behavioral, or physical needs. This includes dependent and/or delinquent youth for whom there is not an appropriate level of care available, such as those sleeping in a CYS office or hotel. This also includes those for whom a higher level of care is recommended, but for whom that level of care cannot be located, is unavailable, or simply does not exist.

Current Landscape

As part of the work group, two surveys were sent to stakeholders. One survey gathered information about the number of youth who have been staying in inappropriate settings due to a lack of any other options. This survey will be discussed further below. The second survey looked at gaps in services and barriers to programming, the dangers of inadequate or inappropriate services, and recommended best practices. As may be expected, the responses focused on increased stays out of the home, placements in more restrictive settings than are truly needed, and worse outcomes for those receiving care.

Survey of Temporary Housing

A survey was sent out to county children and youth offices to gather information on the number of youth forced to sleep somewhere other than a licensed child placement facility. This may be the child welfare office, a hotel, or a hospital ready for discharge, but there is no facility to which they can be moved. Additionally, counties were asked about youth placed in a lower level of care that was inadequate to meet their needs, such as a youth who needs a residential treatment facility but is placed in a shelter. The counties were asked to include data only for the period of January 1, 2023, until June 30, 2023. The forty-five (45) counties responding highlight the critical need for comprehensive and sustainable solutions.

In the work group's analysis of data from these 45 counties, it was found that 255 youth slept somewhere other than a licensed placement facility. Children and youth workers spent more than 772 nights sleeping in offices, hotels, cottages, and hospitals to monitor those youth for whom a placement could not be located. Despite efforts to identify appropriate placements, 175 youth were forced to stay in a hospital beyond their discharge date due to a lack of proper placement. There were at least 2,651 nights spent in the hospital because there was no adequate placement. Additionally, 99 youth did not receive mental health services needed because the hospital could not provide the level of care and simply discharged them, rather than provide further efforts to locate an appropriate placement. The counties identified 284 youth who were placed in a lower level of care than what was recommended, constituting 3,161 nights during which youth were placed in a lower level of care than needed. Some 33 youth were placed outside of Pennsylvania because appropriate placements could not be located for them within the state.

Responsibility for Provision of Mental Health Services

The state's responsibility for ensuring that appropriate mental health services are provided to eligible individuals springs from Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., which establishes the federal Medical Assistance (MA) program. Through the MA program, the federal government reimburses more than half of the expenditures incurred by states that elect to furnish certain healthcare services to eligible individuals. While states are not required to participate in the MA program, if they do so they must comply with Title XIX and its implementing regulations. Pennsylvania participates in the MA program.

Title XIX mandates that a state MA program provide certain specified health care services, per 42 U.S.C. 1396a(a)(10)(A). Section 1396a(a)(43) requires the state plan to "provide for informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance ... of the availability of early and periodic screening, diagnostic, and treatment services." Section 1396a(a)(43)(C) requires the plan to provide for arranging those Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") services. EPSDT is defined to include all "necessary health care, diagnostic services, treatment, and other measures described in section 1396d(a) to correct or ameliorate defects and physical and mental illness and conditions." 42 U.S.C. 1396d(a)(4)(B) and (r)(5).

Services in section 1396d(a) include "other diagnostic, screening, preventive, and rehabilitative services, including....any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." 42 U.S.C. 1396d(a)(13). Residential Treatment Facility (RTF) services, the therapeutic portion of therapeutic foster care, and other community-based mental and behavioral health services prescribed by a medical professional, except for room and board, are covered services.

Title XIX also requires that MA services "shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. 1396a(a)(8). The Pennsylvania Department of Human Services (DHS), through the Child Welfare system and its Office of Medical Assistance Programs, is responsible for providing appropriate mental health care. DHS funds and arranges for the provision of certain mental and behavioral health services to children, youth, and adolescents up to the age of 21 who are enrolled in the MA program. While DHS utilizes the counties to provide such services, as the Administrator of the MA program, it is ultimately the state who maintains responsibility to ensure such services are made available to all eligible individuals and that the services are furnished with reasonable promptness.[1]

[1] Sections 1396a(a)(10)(A) and 1396a(a)(8) confer privately enforceable rights upon individuals. S.R. by & through Rosenbauer v. Pennsylvania Dep't of Hum. Servs., 309 F. Supp. 3d 250, 259 (M.D. Pa. 2018). Additionally, the EPSDT mandate, embodied at 42 U.S.C. 1396a(a)(43) and its subparts, also confers a private right of action on individuals. S.R. by & through Rosenbauer v. Pennsylvania Dep't of Hum. Servs., 309 F. Supp. 3d 250, 262 (M.D. Pa. 2018).

Regardless of the statutory and regulatory scheme that Pennsylvania utilizes to meet its requirements under the MA plan, there are increasing gaps in services necessary for youth to receive proper care. In some cases, these gaps are created due to lack of adequate staff to be able to utilize all open beds. In some cases, there are more youth who need treatment than there are available beds or openings, which means that some youth do not receive the care they need because another youth is utilizing the services. In other cases, the level of care may be so unique or complex that the level of care that is capable of meeting the youth's needs does not even exist.

In addition to the prominent delays and gaps in services for MA eligible youth, other significant and serious gaps exist. For example, some youth may be MA eligible but do not have a current mental health diagnosis and lack the ability to receive MA program mental health benefits. These youth are often discharged from hospitals without the ability to receive appropriate care in a licensed mental health facility. As a result, the youth go without the care and treatment that they need and are often discharged to CYS' care.

Likewise, youth who are not MA eligible and who need mental health services are left without any safety net and often have nowhere to turn. The Counties are compelled to try to stretch strained resources to provide some level of care for these youth who may wait years before they receive the services or treatment they need.

Regardless of the reason why an adequate treatment setting is unavailable, the end result is the same. Youth are not receiving the level of care that they need – the majority of who are entitled to those benefits under Pennsylvania and federal law. This is a driving factor in the recommendations set forth below.

Negative Outcomes for Children, Youth, and Staff

This issue with complex cases is not limited to Pennsylvania. Many involved in the field nationwide have been strident about the harms that can befall youth and the staff providing oversight in unlicensed settings. While licensed facilities have staff trained in de-escalation, procedures for behavioral issues, and oversight of psychological professionals, there are no such safety features when a youth is staying in a child welfare office or hotel and being supervised by child welfare workers. At best, this is an inappropriate placement during which youth receive none of their needed treatment and care; at worst, it is a situation dangerous to all involved.

Despite the immediate severity of these issues, there hasn't been the level of concern that is warranted for such situations. Nationwide, there have been numerous examples of disastrous outcomes when child welfare agencies are forced to house youth in offices and hotels. Here in Pennsylvania, Philadelphia has been struggling with this situation, experiencing physical and

sexual assaults occurring against youth and staff, as well as numerous threats.[2] Texas has also seen numerous sexual and physical assaults of staff.[3] Another youth was struck and killed by a car after absconding from the child welfare office where she had been staying.[4] Such placements do not provide for the proper age separation of youth. New Mexico saw an older youth sexually assault a 10-year-old when they were both staying at the child welfare office.[5] Los Angeles had a 16-year-old youth placed at a hotel for lack of an appropriate placement sexually and physically assaulted a child welfare worker providing supervision.[6]

There is no shortage of terrible incidents documented when kids are staying in hotels, children and youth offices, or other inappropriate settings. Many of these youth have been assessed and determined to need structured mental health programs, yet those programs are unavailable. Instead, these youth are staying in places that are not even meant to house youth, while being watched by caseworkers without mental health training or experience. It cannot be a surprise that such negative outcomes result from these situations.

While not as troubling as assaults, youth fatalities, and threatening behavior, a further consequence of unmet treatment and service needs is that counties are forced to act as placement providers. When there is simply no other place for these youth to stay, counties must assume drastically higher levels of liability than is appropriate: child welfare administrative staff—who are not trained mental health professionals—are thrust into the position of providing 24-hour care for youth needing high levels of treatment in a setting that is not equipped to accommodate such youth.

This is a hazardous situation for both the youth involved and the child welfare staff, and it puts further pressure on a child welfare system already under stress from staffing shortages.

Process

As a part of the 2023 County Government Priorities process, CCAP members voted to "address the needs of children and youth who have complex behavioral health issues." In March of 2023, the Association Board established the Complex Case Work Group to develop a report and recommendations that will provide relief to counties and secure crucial services for children.

---

[2] https://www.audacy.com/kywnewsradio/news/local/child-welfare-testify-state-kids-sleeping-on-floor-philadelphia-dhs

[3] https://www.kxan.com/news/texas/attacks-on-workers-spike-with-more-foster-care-children-sleeping-in-texas-cps-offices/

[4] https://www.texastribune.org/2017/04/03/houston-foster-child-death-spurs-concerns-over-placement-shortages/

[5] https://www.abqjournal.com/news/local/child-10-allegedly-sexually-assaulted-by-foster-teen-at-cyfd-office/article_6e94504f-d321-5415-bfd1-419fd764c296.html

[6] https://www.latimes.com/california/story/2023-05-28/foster-children-hotels-social-workers-assaulted

The work group convened its first meeting with CCAP members and county human services staff in July 2023. At the initial meeting, the work group determined that five subcommittees would be formed to look more closely at individual areas related to the issue. The subcommittees were: Communications, Funding and Sustainability, Resource Navigation, Services and Programs, and Staffing and Workforce. Each work group member served on two subcommittees, and there were 6-8 members on each subcommittee.

Over the next six months, the subcommittees each met three times, individually or in combination with another related subcommittee. In addition to the subcommittee meetings, the full work group met three times.

The work group obtained information about work in Pennsylvania, Colorado, Illinois, and a variety of other states to inform the recommendations. Thanks are extended to the experts and stakeholders who presented and discussed ongoing efforts at those meetings.

Recommendations

1. **It is recommended that the state develop a no eject/no reject program to ensure youth have a safe place to stay if all private providers have rejected them.**

   Responsible parties: *State/Counties/Behavioral Health Managed Care Organizations*

   a) Currently, counties contract with private service and placement providers for services. The Behavioral Mental Health Care Organizations (BHMCOs) contract for the provision of mental health services and fund such services when needed. However, whenever a youth is in the custody of a county agency and needs a placement (for mental health, behavioral needs, or simply foster care) but such placements can't be located, it ultimately falls to the county child welfare agency to provide a placement for those youth. This has resulted in numerous youth sleeping in child welfare offices, hotel rooms, and overstaying in emergency rooms beyond when they are ready for discharge.

      There is a need to develop a program that will ensure youth are no longer forced to stay in these inappropriate and unlicensed placement settings. A diagnostic and/or stabilization program, that will accept any youth for stabilization and testing, would be appropriate to ensure youth are staying in a safe program until a more long-term program can be located. This could take the form of regionalized programs to enable youth to remain closer to their families and prevent extensive travel costs.

      In the delinquency placement system, it is recognized that there must be a program to accept any youth when all other programs have refused placement or been tried and found ineffectual. That understanding is no less essential for dependent youth.

2. **It is recommended that more organized and concerted efforts be made to develop programs to accept challenging behaviors, co-occurring medical and mental health issues, and other patterns of diagnosis which are proving to be the most challenging to find appropriate placements.**

   Responsible parties: *Counties/State/Behavioral Health Managed Care Organizations*

   a) Through the CCAP Complex Case Work Group meetings and other settings, it is evident that there has not been a concerted and organized effort to create needed programs. For instance, many of our complex cases are the result of mental health conditions co-occurring with a physical condition, developmental disability, or autism spectrum diagnosis.

      While any given county may have custody of a single youth with such a combination of symptoms that their current array of services is unable to meet the youth's need, if one were to look at a statewide level there would be enough such youth to warrant the creation of programs to meet these needs. Unfortunately, the inconsistent nature of these occurrence means that individual counties and BHMCOs are unlikely to recognize the whole number of youth requiring such placements; therefore, necessary programs are never created.

      It is critical that the state, providers, BHMCOs, and counties work together through the complex case referral process, identifying the specific needs to be met and developing programs in an organized and committed manner.

   b) An additional theme that became evident through the work group was that many providers are giving referred youth a superficial assessment to determine whether they are a good "fit" for their programs. It should be incumbent on providers to complete a comprehensive assessment to determine whether a youth is likely to make progress in their program, with the understanding that best practices and individualized service plans would be utilized to maximize the chance of success. Only after considering if individualized services and an array of best practices will still not enable a youth to be successful in a program should youth be rejected.

   c) A frequently mentioned issue is when youth who exhibited problematic behavior in the past are not accepted into a program, even after the behavior has not manifested itself for many years. For instance, a youth who acted out aggressively when they were 10 but are now 15 without there having been any further acts of aggression. A youth's profile should evolve and focus on recent behaviors. Their goals should be based on current maladaptive behaviors, rather than focusing treatment on long past behavioral issues.

d) To improve the overall array of services and placement options available within the state, there should be greater efforts to develop incentives for providers for taking more challenging youth, a means to address the increased liability that comes with taking more challenging youth, as well as the means to set individualized rates when implementing a unique and complex individualized service plan.

3. **It is recommended that there be collaborative cross-systems trainings and coordination.**
   Responsible parties: *State/Counties*

   a) It is recommended that regular trainings be established for county and state personnel addressing complex cases so all may better understand the available resources and limits for different funding streams. These trainings should identify how best to braid funding streams, leveraging existing services while identifying service areas in need of further development. It is recommended that a conference be developed for this purpose, along with resources to improve the complex case referral process.

   b) It is recommended that regionalized consultation teams consisting of county, state, and private experts in this field be developed and available for consultation when addressing these youth. A benefit of this team is that, as they resolve more issues with challenging placements, they develop ever greater levels of expertise in handling such cases.

   c) It is recommended that the Complex Case Bulletin be revised to require state offices to participate sooner in the process than is currently occurring. There should be more focus on state entities assisting with providing assistance in alleviating funding, waiver, and service challenges, rather than requiring repetitive action to be taken by the county before assistance can be provided. Instead of requiring that counties contact every service provider in the state (even those who do not accept youth of that age, gender, or diagnosis) the state should take a commonsense approach to these inquiries. The bulletin should focus on the shared responsibility for youths' proper care, emphasizing collective responsibility.

4. **It is recommended that there be regulatory and policy changes to enable existing funding streams to better address complex cases.**

   Responsible party: *State*

   a) A consistent theme has been the siloing of funding streams. This has occurred for many years, despite various administrative agencies speaking to the need to "braid" funding. Braiding means to use various funding streams to funds parts of

a youth's overall needs, such as developmental disability funds to pay for some part of services, while child welfare pays for the housing and care, and mental health pays for treatment. Despite being discussed for so many years, there has been little guidance and flexibility provided when it comes to actual implementation.

There is a need to establish a group who has the authority to approve the use of their respective funding streams in order to expedite the arrangement of services and funding for youth needing the services. While the current regulatory structure and approved use of funds works for most youth, there needs to be a much easier process to combine funding when the youth do not fit neatly into the existing regulatory scheme. Too many funding streams demand to be the payer of last resort; however, it is impossible for all funding to be the last utilized. It may be necessary to develop a funding stream that can act as a reserve to pay for needs that are unable to be met by other funding streams.

b) The current levels of care are insufficient to meet the needs of today's youth. It is recommended that the state Medical Assistance plan be modified in such a way as to allow for more levels of service, such as weekend treatment facilities, evening programming, and expanded respite care. T A fuller range of services can be utilized to allow more youth to remain at home, providing families with a level of support that will prevent unnecessary placements.

c) It is recommended that the state consider creating a liability coverage pool for providers, such as is done for high-risk drivers, or that a contingency fund be created to assist providers with unforeseeable dramatic increases in their liability insurance coverage. Timing for the Needs-Based Plan and Budget (NBPB) creates a lag between when funding is needed and when it is available in terms of providers. While providers submit their anticipated rate increases to counties in advance of the NBPB, insurance rates are provided to providers after those rates are included in the budget; as a result, providers may be requesting dramatically higher rates from the counties than will be covered by the NBPB.

The creation of a contingency fund to cover providers' unforeseen insurance increases would result in a healthier and more stable provider network; an increase greater than 10% from anticipated would be a good place to start.

d) It is recommended that the current children and youth office licensing structure be changed to better align the needs of youth. As the only state that formally licenses county child welfare agencies, it would be thought that there would be some dramatic differences in outcomes compared to all the other states that do not license. There is no difference in outcomes between Pennsylvania and other states.

The reality is that substantial time and effort is spent by counties on technical compliance with a checklist that has little to do with improving practice. One missed signature out of fifty documents reviewed certainly is not indicative of a systemic problem yet will result in a citation and a need for corrective action on behalf of the county, with follow-up by regional DHS officials. Such focus by DHS staff on inconsequential county infractions means DHS staff is not available to engage in more meaningful technical assistance that improves outcomes.

It is recommended that licensing be eliminated between governmental entities and the focus changed to how the state and counties can work together to improve outcomes for youth and families. As long as the state's responsibility is to issue citations and tell counties what regulations may have been violated, there is little motivation for the state to provide meaningful assistance to the counties to improve the practice. The existing system means that counties are often reluctant to reach out to regional officials for assistance. County directors express that reaching out is unlikely to result in help and highly likely to result in citations and the ensuing corrective action plans, further eroding the ability of counties to improve practice.

If the elimination of licensing is impossible, at a minimum licensing should be changed to be based on the outcomes that the Administrations for Children and Families actually looks at for states. These outcomes include timely investigations, family engagement, and other factors in the Child and Family Service Review. Accountability could be readily provided by the use of public access to information to see how counties and the state are performing in critical areas. Many states already use this system. Some examples are set forth below.

Colorado
https://www.colorado.gov/pacific/cdhs/child-welfare-policies-data-accountability

California
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx

Florida
https://www.myflfamilies.com/ocfw-dashboard

Arizona
https://dcs.az.gov/news-reports/performance-measures

5. **It is recommended that the state and counties look to leverage technology to free up staff time and improve outcomes by allowing staff to spend more time working with families.**

   Responsible parties: *State/Counties*

   a) In the course of the work group, the FirstMatch program was reviewed. When a referral is made through FirstMatch, the program looks at a youth's needs and assesses the likelihood of success in a particular program based on the prior outcomes of programs regarding youth with similar diagnoses. This is represented as a percentage of likelihood for success. Ensuring youth are appropriately referred has multiple benefits. It saves frustration for youth and families who avoid their loved one being sent to programs that are unlikely to be effective. It reduces programs placements being used for youth that are going to be unsuccessful in that program, thereby allowing those spots to be used by other youth who are more likely to be successful.

      It is recommended that the state purchase or develop a FirstMatch type program, enabling a single referral and an improved identification of program matches for all available placement resources statewide. This program should make clear the inclusion and exclusion factors for placement within the specific services. Additionally, this will identify gaps in services and allow for the development of needed services.

   b) Counties should look to utilize technology to streamline routine tasks and free up caseworker time to work with families. Most caseworkers enter the field to work with families and become frustrated when they find they are spending most of their time completing mundane clerical activities, rather than helping families. Some possibilities for time-saving technologies are listed below, although there are many others available. CCAP and this work group do not endorse any specific products or services.

      Automated drug testing: Clearlee https://clearlee.com/
      Dictation services: Speakwrite https://speakwrite.com/
      Natural language search programs: Augintel https://www.augintel.us/aws
      Use of AI and algorithms
      Improved user interfaces
      Improved document handling programs: Northwoods https://www.teamnorthwoods.com/
      Virtual reality to improve training:
      Accenture https://www.accenture.com/us-en/services/public-service/caseworker-virtual-reality
      Virtual Social Worker Trainer https://vswt.utah.edu/

6. **It is recommended that greater emphasis be placed on improving staffing throughout child welfare in the state. This must include state, county, and private provider staff in order to build a strong and resilient workforce capable of meeting the needs of children and families in the state.**

   Responsible Parties: *State/Counties/Behavioral Health Managed Care Organizations*

   a) Steps should be taken to professionalize the field of child welfare. Outreach efforts should be made at universities, and even high schools, to get more people interested in the field.

   b) There must be a concerted effort on the part of state oversight entities to expedite restraint investigations and eliminate the duplication of efforts. This would allow staff to return to work sooner, eliminate the waste of time in meeting the demands of multiple oversight authorities, and reduce trauma on youth who are at the basis of these investigations. The vast majority of these investigations are unfounded yet pull staff out of the workforce for several weeks. It is not uncommon for these staff to simply move to other positions, as financial restraints do not allow long periods of time without being paid.

   c) Focus should be made on providing internships to get people interested in the field. The University of Pittsburgh's Child Welfare Education for Baccalaureates (CWEB)[7] and Child Welfare Education for Leadership (CWEL)[8] programs are excellent resources to improve interest in child welfare, but there is not a similar program for providers. Greater efforts could be made to ensure workers in child welfare have their student loans paid while they are employed to further incentivize the work.

   d) There should be a statewide advertising campaign to increase interest in the field of child welfare. While some counties do this already, it is not possible for all counties to mount such efforts.

   e) There should be 100% salary reimbursement for county child welfare staff, empowering counties to better compensate their staff and allow counties with minimal tax bases to increase salaries. The current salary spread in Pennsylvania is between $28,000 and $60,000 for the exact same position. With such dramatically differing starting salaries for the same work, it becomes frustrating for counties on the lower end of the salaries to compete for staff with those paying more. A reduced curve in the starting salaries would benefit counties, as

[7] https://www.socialwork.pitt.edu/researchtraining/child-welfare-programs/child-welfare-education-baccalaureates
[8] https://www.socialwork.pitt.edu/researchtraining/child-welfare-programs/child-welfare-education-leadership-cwel

there would be less incentive to take a job, get trained, then move to another county paying more.

f) It is recommended that there be a statutory floor for caseworker salaries to ensure qualified, competent child welfare professionals are working with families. It is recommended that $45,000 be the minimum starting salary, so long as it is done in conjunction with 100% state reimbursement for salaries. This minimum salary should be reviewed and adjusted at least bi-yearly.

g) It is recommended that the state promulgate the regulations regarding the lowering of caseloads that have been in the works for years. The current regulation of 30 families per caseworker is manifestly unrealistic. Caseload sizes should be targeted at ten to twelve cases per caseworker, as research shows that this is the most realistic caseload size to provide effective case management.

7. It is recommended that Pennsylvania develop a mental health resource navigation system to assist families with locating needed services and navigating the mental health system.

Responsible parties: *State/Counties/Behavioral Health Managed Care Organizations*

The Complex Case Work Group wishes to acknowledge and thank the Illinois Children's Behavioral Health Transformation Initiative and Chapin Hall at the University of Chicago for their Blueprint for Transformation Report from which this recommendation was modified for Pennsylvania.[9]

a. Pennsylvania should develop a centralized resource line for families seeking services for children and youth with significant and complex needs, similar to the KinConnector resource. The mental health system can be confusing and frustrating for those not familiar with it. Families need to know where to obtain information, referrals, and guidance for obtaining services for children and adolescents experiencing mental health problems. Too often, families attempt to seek out services, only to become so frustrated that they quit trying to obtain them. This leads to youth needing higher levels of care and more serious disruption in the family, as the lower level of treatment is not received. Information on how to navigate the insurance, treatment, and family rights issues surrounding mental health care should be readily available and could help to divert youth from the dependency or delinquency systems. Ensuring youth get the needed treatment, without undue delay, is critical to the prevention of mental health crisis and ensuring those higher levels of care are not overwhelmed by patients who could have been treated at a lower level of care.

[9] https://www2.illinois.gov/sites/gov/Documents/childrens-health-web-021523.pdf

A robust resource line for children, youth, and families seeking behavioral health services could provide coordinated, cross-agency support to help families identify and access services to address their specific needs. Depending on the level of need, the resource line could link families to Resource Navigators, existing warm/hotlines for informal assistance, and specialized guidance to begin the process of accessing care. This "front door" creates a new option for families to augment agency-specific paths, streamlining the user experience to direct families to the programs and services most equipped to meet their treatment needs with the most appropriate level and type of care. This approach can reduce the administrative burden on families by minimizing documentation requirements and submission of information at multiple points, promote information sharing to enhance collaboration, and provide a data source for accountability and ongoing monitoring of capacity to deliver needed services.

A public-facing resource line will demystify the process of seeking residential treatment and allow concerned, involved adults (for example, parents, guardians, family members, teachers) to enter information and obtain a list of programs and services for which a youth might be eligible. Several state and local jurisdictions have intake forms or portals that allow them to triage cases based on need.

Examples included:

The Washington Mental Health Referral Service for Children & Teens
https://www.dcyf.wa.gov/services/foster-parenting/mental-health-referral-service

Massachusetts Behavioral Health Help Line (BHHL)
https://www.masshelpline.com/

New Jersey Mental Health Cares resource site
https://www.njmentalhealthcares.org/

Colorado operates both a crisis line and a resource navigation website https://bha.colorado.gov/
https://coloradocrisisservices.org/

Families seeking residential placements will still likely require assistance from resource navigators, who can help families understand and identify mental health resources and the processes for obtaining them. Resource navigators are critical to helping families navigate a complex mental health system and understand what they qualify for based on their insurance, the specific needs of their child and what resources might address those needs, as well as which supplemental resources, programs, and services that might alleviate the need for acute care or complement existing supports.

Attachments:

Executive Summary

Service Mapping Tool for Counties

CCAP Complex Case Workgroup Executive Summary

February 2024

As a part of the 2023 County Government Priorities process, CCAP members voted to "address the needs of children and youth who have complex behavioral health issues." In March of 2023, the Association Board established the Complex Case Work Group to develop a report and recommendations. The goal of this report is to establish practical and immediate strategies to protect our most vulnerable children and youth.

What are complex cases?

Minors who are in the custody of the county for whom there is not a level of care sufficient to meet their mental, behavioral, or physical needs. This includes dependent and/or delinquent youth for whom there is not an appropriate level of care available, such as those sleeping in a Children and Youth Services office or hotel. This also includes those for whom a higher level of care is recommended, but for whom that level of care cannot be located, is unavailable, or simply does not exist.

Current Landscape

For the period January 1, 2023, until June 30, 2023, 45 counties were able to provide data on the number of youth forced to sleep somewhere other than a licensed child placement facility. This may be the child welfare office, a hotel, or a hospital ready for discharge, but there is no facility to which they can be moved. This includes youth placed in a lower level of care than needed.

- 255 youth slept somewhere other than a licensed placement facility.
  - 772 nights sleeping in offices, hotels, cottages, and hospitals
- 175 youth were forced to stay in a hospital beyond their discharge date.
  - At least 2,651 nights unnecessarily spent in the hospital.
- 99 youth did not receive mental health services needed because the hospital could not provide the level of care and simply discharged them.
- 284 youth who were placed in a lower level of care than what was recommended
  - 3,161 nights during which youth were in a lower level of care than needed.
- 33 youth placed outside of Pennsylvania when in state placements couldn't be located

Negative Outcomes for Children, Youth, and Staff

Nationwide, there have been numerous examples of disastrous outcomes when child welfare agencies are forced to house youth in offices and hotels. Texas has seen numerous sexual and physical assaults of staff. Another youth was struck and killed by a car after absconding from the child welfare office where she had been staying.

Such placements do not provide for the proper age separation of youth. New Mexico saw an older youth sexually assault a 10-year-old when they were both staying at the child welfare office. Los Angeles had a 16-year-old youth placed at a hotel for lack of an appropriate placement sexually and physically assaulted a child welfare worker providing supervision.

Recommendations

State development of a no eject/no reject program to ensure youth have a safe place to stay when there are no other options. When a county agency is unable to locate an appropriate placement for a child in their custody, those agencies may sometimes be forced into having youth sleep in hotels or county agency building, while being cared for by child welfare staff. It is imperative that there be a program developed that will ensure that youth no longer are forced to stay in these inappropriate and unlicensed placement settings. While there are such programs in the delinquency system, there is no such equivalent for dependent youth.

Responsible parties: *State/Counties/Behavioral Health Managed Care Organizations*

More organized and concerted efforts be made to develop programs to accept challenging behaviors, co-occurring medical and mental health issues, and other patterns of diagnosis which are proving to be the most challenging to finding appropriate placements.

Responsible parties: *State/Counties/Behavioral Health Managed Care Organizations*

Collaborative cross-systems trainings to allow county teams and state personnel who address complex cases to better understand the available resources and limits for different funding streams, how to leverage existing services, and to identify areas in need of further service development.

Responsible parties: *State/Counties*

Regulatory and policy changes to enable existing funding streams to better address complex cases. There is a need to establish a group who has the authority to approve the use of their respective funding streams in order to expedite the arrangement of services and funding for youth needing the services. The state Medical Assistance plan should be modified to allow for more levels of service, such as weekend treatment facilities, evening programming, and expanded respite care.

Responsible party: *State*

State and counties leverage technology to free staff time and improve outcomes by allowing staff to spend more time working with families. The state should purchase or develop a FirstMatch-type program to enable a single referral and an improved identification of program matches for all available placement resources statewide.

Responsible parties: *State/Counties*

Greater emphasis on improving state, county, and private staffing throughout child welfare in the state in order to build a strong and resilient workforce capable of meeting the needs of children and families in the state.

Responsible parties: *State/Counties/Behavioral Health Managed Care Organizations*

Develop a Pennsylvania mental health resource navigation system to assist families locating needed services and navigating the mental health system, such as the KinConnector resource.

Responsible parties: *State/Counties/Behavioral Health Managed Care Organizations*

Children and Youth Service Mapping for Counties

County Children and Youth Offices assist their clients with a wide range of possible services to meet individual and family needs. Each county may have different services and providers available. This brief service mapping guide is intended to assist a county with a basic inventory of such services. This could assist with coordination between agencies when providing for a particular individual or family to ensure all possibilities are more easily referenced. It could also identify gaps where a service needs to be identified. This list includes many of the most common types of services but may not be exhaustive.

For each category below, identify the following:

Name of service

Provider

Description of service

What level of acuity/risk does it serve?

Target Population

Is this a mandated service?

Ages served

How many does it serve?

How much does it cost?

What is the funding source?

How many participants does the program need to succeed?

Mental Health

Child mental health

Child requires evaluation to ascertain mental health issues

Child acts out aggressively

Child exhibits problematic sexual behaviors

Child diagnosed with mental condition requiring treatment

Child exhibits trauma response

Child requires psychotropic medication monitoring

Child requires supportive services-Peer support/support group/etc.

Parent mental health

Parent requires evaluation to ascertain mental health issues

Parent acts out aggressively

Parent exhibits problematic sexual behaviors

Parent diagnosed with mental condition requiring treatment

Parent exhibits trauma response

Parent requires psychotropic medication monitoring

Parent requires supportive services-Peer support/support group/etc.

Parent-Child Interaction

Substance abuse issues

Parental Use

Parent requires an evaluation to determine treatment needs

Parent requires inpatient treatment

Parent requires outpatient treatment

Parent requires supportive services such as peer support or AA

Child Use

Child requires an evaluation to determine treatment needs

Child requires inpatient treatment

Child requires outpatient treatment

Child requires supportive services such as peer support or AA

Environmental Issues

Homeless

Unable to continue to pay for housing

Unable to afford utilities

Unsafe home conditions

Need furniture or other items

Dirty or hoarding issues

Violence

Parental violence toward child

Domestic violence

Developmental issue

Parent Intellectual Disability

Parent needs an evaluation of need

Parent requires supportive services

Child Intellectual Disability

Child needs an assessment of need

Child requires supportive services

Medical issues

Parent has medical issues limiting or impairing parental ability

Child has medical issues requiring specialized care

Child is pregnant

Supervision

Parent unable to determine appropriate level of supervision

Parent unwilling to provide adequate supervision

Parental resources and supports do not provide for adequate supervision

Employment

Parent is unwilling to seek employment

Parent is unable to obtain employment

Parent needs supportive services to enhance employability

Human Trafficking

Child needs counseling for Commercial Sexual Exploitation of Children (CSEC)

Child needs a residential program specialized to human trafficked populations

Educational Issues

Child needs educational assessment

Child needs supportive educational services

Child needs truancy program

Parent needs educational services such a basic literacy training