
GOVERNOR’S BEHAVIORAL HEALTH SERVICES PLANNING COUNCIL
CHILDREN’S SUBCOMMITTEE

PRESENTED TO

Wes Cole, Chair
Governor’s Behavioral Health Services Planning Council

Laura Howard, Secretary
Kansas Department for Aging and Disability Services

Laura Kelly, Governor
State of Kansas

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INTRODUCTION

The children's subcommittee chose three topics this year to focus on: 1. strategies of prevention that will help maintain children with their families, 2. barriers for caregivers in regards to communication and coordination of services and resources, and 3. the effects of online content and technology on children's behavioral health.

1. The Department of Children and Families (DCF) was in the middle of reviewing Family Preservation and Prevention Service Grant applications as we were selecting topics to look at this year. As a large proportion of children that receive behavioral health supports and services are involved in the child welfare system, we are naturally interested in looking at what can be done to support children and families and prevent them from entering the system to begin with.
2. Our subcommittee often discussed the issues that arise due to poor communication and coordination of services. Unfortunately, these issues largely impact the children and families involved and are often cited as barriers to services when we talk with parents.
3. And finally, we often discussed as a subcommittee the new and changing challenges that children and families face that are due to online content and technology. These issues range from online bullying and the impact of individual and groups of children, human trafficking, and addictions to cellphones, video games, and easy access to online gambling/games of chance. Technology is a wonderful tool, however there are often negative consequences of that technology. We wanted to dedicate some time to understanding those consequences and make some informed recommendations related to children's behavioral health.

This report also includes a list of the highlights of progress our subcommittee has heard of and wants to acknowledge, information about the Legislative Day we co-hosted with the prevention subcommittee, a report from the Kansas KidsMAP project, and some thoughts and recommendations related to what we have observed and learned regarding COVID, and specifically the use of telehealth during the COVID pandemic.

SUMMARY OF RECOMMENDATIONS

Subcommittees were asked to prioritize recommendations and include any funding information we can. As we had initiated and completed much of our work before receiving this request our report lacks this information. However, we have included information we were able to add in the summary below. We will also integrate this request into our work next year.

Goal 1: Identify strategies of prevention that will help maintain children with their families.

1. Increase investments in Prevention Services
2. Increase investment in Family Preservation Services
3. ***Increase investment in a support of Kinship Care****

*We would prioritize any new investment for foster care to support increased payments and support for Kinship Care. Small investments made would help grow a more robust Kinship Care program in Kansas, and align with Family Finding work.

We also included a list of other recommendations related to foster care/youth.

Goal 2: Identify barriers for caregivers and other support services and recommend solutions for better communication and coordination of resources.

1. The state should support providers so that staff who deliver information do so following best practices (detailed in the report below).
2. The state should consider policy, procedure, and funding changes to support, whenever possible, centralized support for families. Such changes would result in changing the experience of families so they speak with a person like a case manager or concierge rather than many different people at many different organizations.

Goal 3: Research the negative effects of online content and technology and how it impacts children's behavioral health and make recommendations.

1. Follow and promote the use of The American Academy of Pediatrics Guidelines for Screen time for kids.

COVID & Telehealth

1. Continue allowing use of telehealth codes and processes that were created so that we can gather some data and further study the use of these processes.
2. The state should work with stakeholders to develop a protocol(s) to identify when to use telehealth or not.
 - Protocols include considerations of confidentiality and potential impact on care.
 - The protocols should include a recommended method (and resources) for evaluation

Highlights of Progress

Our role is to make recommendations regarding improvements to behavioral health services for Kansas children and their families. Our work often focuses on “what’s wrong” or “not working right.” We realized that we need to model as a subcommittee the strengths based approach we hope the state supports and Kansas providers use when working with children and families. With that goal in mind we wanted to highlight some of the positive work we know happened and is happening in Kansas this past year.

- We greatly appreciate that Kansas prioritized and lead the implementation of Family First Prevention Act services. Thank you to DCF and the Kansas Legislature for these efforts.
- The Pediatrics Supporting Parents Medicaid Workgroup Phase 1 was a success. We thank KHDE, the United Methodist Health Ministry Fund, and others who supported this work, including drafting of an impact paper detailing the results of allowing pediatricians to bill Medicaid for maternal depression screenings for up to one year in pediatric settings when the child or mother is Medicaid eligible. This is a great step that will help support continued improvements in maternal and child health and changes in Medicaid to that focus on family wellness rather than just the mother or child.
- We appreciate KDADS’ efforts to track and share Psychiatric Residential Treatment Facilities (PRTF) and waiting list numbers.
 - We appreciate KDADS’ implementation of a weekly review of children on the PRTF list with MCOs and other interested parties. This has helped result in a drop in the waiting list
 - We also appreciate the work of KDADs in working with providers to open up “specialty” PRFT beds for children/youth with high acuity, sexualized behavior, autism spectrum diagnosis, and SUD/MH.
 - This work has impacted the decision of organizations to be able to open more PRTFs.
 - We want to specifically highlight the leadership role of Gary Henault to champion these efforts and make such significant progress in a short period of time.
- We have been impressed by how quickly the KSKidsMAP project got up and running. This is largely due to the wise decision of leaders in KDHE to build upon existing work, and has resulted in a fast start-up with a large number of participants across most of the state. In addition, the reports provided by KSKidsMAP to this subcommittee also informs us that those involved in the project know the work that needs to happen next and their plan for addressing those next steps.
- We appreciate the speed and efficiency that the state opened up the codes to increase access and use of telehealth during the COVID pandemic.

2019 - 2020 GOALS AND ACCOMPLISHMENTS

Legislative Breakfast

On January 14, 2020 the Prevention and Children's Subcommittees hosted a breakfast on the 1st Floor-North Wing of the Capitol focused on educating and engaging key legislators in our work. Governor Kelley provided a welcome, both subcommittees presented our individual work and how our work overlaps. Attendance was good and the event helped get the subcommittee's work in front of more legislators.

Goal 1: Identify strategies of prevention that will help maintain children with their families.

Recommendations:

1. Increase investments in Prevention Services
2. Increase investment in Family Preservation Services
3. Increase investment in a support of Kinship Care

Prevention Services

Prevention services target children and their caregivers before they enter the child welfare system and prevent abuse, neglect, maltreatment, etc. from occurring. We consider and recommend Prevention Services first because the recommendation/options presented can have the broadest system-wide impact. Research has shown that an increased investment in Prevention Services impacts quantity as well as quality: it reduces maltreatment episodes, the number of referrals to the child welfare system, and consequently the number of substantiated cases being served by the child welfare system.

Extensive research on Adverse Childhood Experiences (ACEs) has demonstrated the direct impact of trauma on the health of adults that result from abuse and neglect in childhood. Reducing the occurrence of maltreatment and the resulting involvement with the child welfare system translates into improved outcomes for these children throughout their childhood, youth, and adulthood. Research indicates that prevention services prevent such abuse and neglect, and also indicates a decrease in substance abuse, underemployment, homelessness, and criminal conviction. Research also indicates reducing maltreatment results in other benefits for children such as improved mental and physical health outcomes and increased educational attainment. Other benefits include improved infant and child health and development and maternal outcomes, greater workforce participation, and less reliance on public assistance.

Increasing preventive services requires new expenditures to provide services to more children and families. Quality increases can be achieved by allocating resources to implement best practices.

Another benefit of an increased investment in prevention services, is an expected reduction on spending for other more intense services later on. For example, reductions in spending on screenings, investigations, services, and temporary placements may occur as fewer children enter the child welfare system. These reductions only capture the direct costs of the child welfare system paid by the government and do not reflect any government cost savings that

occur in related areas, such as the criminal justice system, physical and mental health care, social services, and education.

Family Preservation Services

We recognize that DCF and the state of Kansas recently invested additional funds and resources into Family First funded Family Preservation Services. That investment was significant and we are waiting to see the impact. However, we would be negligent if we omitted a recommendation for increasing resources for such services, due to the positive impact and the demonstrated need for additional services.

Family preservation services focus on families already involved in the child welfare system, and do not have a significant impact on the rate of maltreatment or the number of children entering the child welfare system. However, such services do affect the children and families involved in the child welfare system including the ultimate outcome of the case and the likelihood of reentering the system. Family preservation services support families, increase the likelihood that they are able to stay together and that the child will avoid subsequent abuse and neglect. Such services also tend to increase the likelihood of reunification with family as a permanent outcome when out of home placement occurs.

Research indicates that systematic implementation of family preservation services results in better outcomes in young adulthood, including fewer disruptions and out-of-home placements, and decreases in substance abuse, criminal conviction, homelessness, and underemployment. Such services also provide cost savings. These savings are realized due to services being provided in-home, which is less expensive than out-of-home placements, and the average duration in care for children who remain or reunify with family is shorter than for children who have other permanency outcomes. These factors, when implemented systematically, more than offset the increased costs associated with providing family preservation services and lead to cost savings.

Kinship Care

We recommend that DCF increase Kinship Care options, and revisit ways to provide improved reimbursement rates for Kinship Care. Increases in temporary kinship care and permanency outcomes with kin led to improvements in outcomes in young adulthood for substance abuse, criminal conviction, homelessness, and underemployment. However, most significantly, Kinship Care helps maintain connection with family and community, and their culture which has a significant impact on the development of the child, young adult, and adult.

Kinship care also helps systems realize cost savings, largely because kinship care placements are less costly than other types of out-of-home placement. Research has shown that these cost savings are enough to offset the increased expenditures on services and supports to promote kinship care.

Other Recommendations for DCF regarding foster care youth

1. We recommend that all Child Welfare contractors encourage and support youth/young adults to stay in custody after turning 18 to access resources and services. Contractors should also only encourage kids to sign out when it is in fact in the youth's best interest.
2. We also recommend that DCF change policies to allow youth that have signed out to be able to get back into the system. Once a youth signs out they are unable to access resources that would have been available had they not signed. We recommend that DCF allow youth to access those resources once they realize that signing out cost them access to those resources.
3. We recommend that the social worker/case worker most connected to the youth stays with them after they age out for a period of "aftercare." OR another mentor, such as a former teacher, foster parent, gets compensated to help the youth. We would recommend this contact be at least monthly, and that the responsibility for initiating contact be on the case manager and not the teen, and last for an aftercare period of 2 years.
4. We recommend that DCF change policy and procedures to remove the burden from the youth to contact DCF for funds and services after they have aged out. This recommendation aligns with the above recommendation that child welfare contractors or DCF make reasonable efforts to stay in contact at least monthly with children after they sign-out for a period of 2 years.
5. We recommend that in situations where the youth is in a supportive foster home on their 18th birthday, that financial support is available to the family to help "launch" the youth on to the next phase, with resources for housing, utilities, educational support, building credit, and job coaching.
6. We recommend DCF require a Best Interest Staffing (BIS) to help the foster youth identify the mentor/adult whom they most trust who can help them towards interdependence through their 23rd birthday.
7. We recommend that the current MAPP classes/curriculum be modified/augmented to establish a new program to help specialized foster parents be mentors for older youths. Classes should focus on brain development, needs of older youth, basic living skills, interdependence, and knowledge of local resources that will help youth live healthy and interdependently.
8. We recommend DCF work with other state agencies to increase the availability of and supports for foster children to access safe and affordable housing. The state should work with agencies across the state to find viable housing options if the child wishes to remain in state custody and have access to these homes —not so clustered together that it becomes hazardous for the youth and the community but mingled in with engaged community members who live interdependent lives. It must be close to employment opportunities and

behavioral health services, and be able to tap into and coordinate with different local programs. We would recommend that youth be required to follow certain rules, such as not allowing drug dependent family members to live in the homes—and permitting consistent contact with “mentors” for accountability and support.

9. We recommend that policies and procedures be changed to allow more flexibility in the use of funding to support all youth, and especially in foster care. There is no single program that works for all youths, flexibility and choice in services and therefore in the way funding is used is required. *Money Follows the Person Model.

These recommendations are based on brain development research that indicates that the pre-frontal cortex (the seat of logic and reasoning) is not fully developed until age 26 for most people. Research indicates that children who have suffered abuse or neglect often are behind their peers developmentally. Foster children who age-out of the system have generally not fared well while in the system, and it does them a huge disservice to tie services to the age of 18.

Goal 2: Identify barriers for caregivers and other support services and recommend solutions for better communication and coordination of resources.

Grandparents with Custody/Caregiver Responsibilities

There are many grandparents who raise their grandchildren. It seems resources that are specific to this population are few, and have in fact gone away. For example, there was a funded position that led this work and formed grandparent groups across the state, but this work ended a few years ago. If this was implemented well, grandparents would appreciate these groups and it would help support them.

Information & Communication

One of the most common barriers for families in receiving services is access to information about services (for providers, the community, and family) and the availability of that information in a way that it is communicated clearly and effectively: aka “family friendly”.

Information should be simplified for parents to understand, especially during a stressful time, in a tone that is conversational and not judgmental. Less information is more. Too much information is overwhelming.

Recommendations:

1. The state should support providers so that staff who deliver information do so following these best practices:
 - Demonstrate/communicate understanding and support followed by honest, balanced communication by trauma-informed staff.
 - Focus on their communication, specifically tone and word choice.
 - Deliver information in a way that is conversational and not formal or technical
 - Avoid acronyms or “program specific” jargon.
 - Provide information in a tiered approach.

- Provide universal information for all that is family friendly and in a tone that is inviting.
 - Provide Tier 2 for those who want to know more, demonstrate interest or need, or have questions and
 - Provide Tier 3 for individual conversations for guidance.
 - Focus on 2 or 3 things that you want the families to understand, more than that will be lost.
 - Ask themselves if the information helps build a relationship and support the families.
 - Provide clear, balanced and direct communication initiated by the service provider or school to the caregiver
 - Invite through meaningful requests to receive input about their children and participation in activities designed for families
 - Provide informational sessions about available community resources to greatly enhance caregiver engagement with their child’s community.
2. The state should consider policy and funding changes to support, whenever possible, centralized support for families, so that families experience speaking with a person like a case manager or concierge rather than many different people.

Goal 3: Research the negative effects of online content and technology and how it impacts children’s behavioral health and make recommendations.

The subcommittee spent a considerable amount of time reviewing resources and articles and learning from one of our very own early childhood experts, Rick Gaskell, a member of our subcommittee, who presented a summary of the most relevant and current information regarding media, screen time, brain development, and behavior.

In summary, there is a plethora of research and resources that already exist. There is however, a lot that is simply unknown. Technology is a tool that should be used with a purpose. There is limited research on the benefit or detriment of screen time on some children.

Therefore, our **Recommendation** is to

1. Follow and promote the use of The American Academy of Pediatrics Guidelines for Screen time for kids.¹

We would like to highlight a few of those recommendations that would be most helpful to the state:

- **Limit digital media for your youngest family members.** Avoid digital media for toddlers younger than 18 to 24 months other than video chatting. For children 18 to 24 months, watch digital media with them because they learn from watching and talking with you. Limit screen use for preschool children, ages 2 to 5, to just 1 hour a day of high-quality

¹ <https://www.aap.org/en-us/about-the-aap/aap-press-room/news-features-and-safety-tips/Pages/Children-and-Media-Tips.aspx#:~:text=Avoid%20digital%20media%20for%20toddlers,day%20of%20high%2Dquality%20programming.>

programming. Again co-viewing is best when possible and for young children they learn best when they are re-taught in the real world what they just learned through a screen. So, if Ernie just taught the letter D, you can reiterate this later when you are having dinner or spending time with your child.

- **Set limits and encourage playtime.** Media use, like all other activities, should have reasonable limits. Unstructured and offline play stimulates creativity. Make unplugged playtime a daily priority, especially for very young children.
- **Know the value of face-to-face communication.** Very young children learn best through two-way communication. Engaging in back-and-forth "talk time" is critical for language development. Conversations can be face-to-face or, if necessary, by video chat with a traveling parent or far-away grandparent. Research has shown that it's that "back-and-forth conversation" that improves language skills—much more so than "passive" listening or one-way interaction with a screen.
- **Screen time should not always be alone time.** Co-view, co-play and co-engage with your children when they are using screens - it encourages social interactions, bonding, and learning. Play a video game with your kids. It's a good way to demonstrate good sportsmanship and gaming etiquette. Watch a show with them; you will have the opportunity to introduce and share your own life experiences and perspectives, and guidance. Do not just monitor children online, interact with them - you can understand what they are doing and be a part of it.
- **Be a good role model.** Teach and model kindness and good manners online. Because children are great mimics, limit your own media use. In fact, you'll be more available for and connected with your children if you're interacting, hugging and playing with them rather than simply staring at a screen.

Advisory Committee for KSKidsMAP Pediatric Mental Health

Our subcommittee served as an advisory committed for the KSKidsMAP Pediatric Mental Health project. This section includes a report summarizing the amazing work of this project.



Summary Report: July 2019 – June 2020

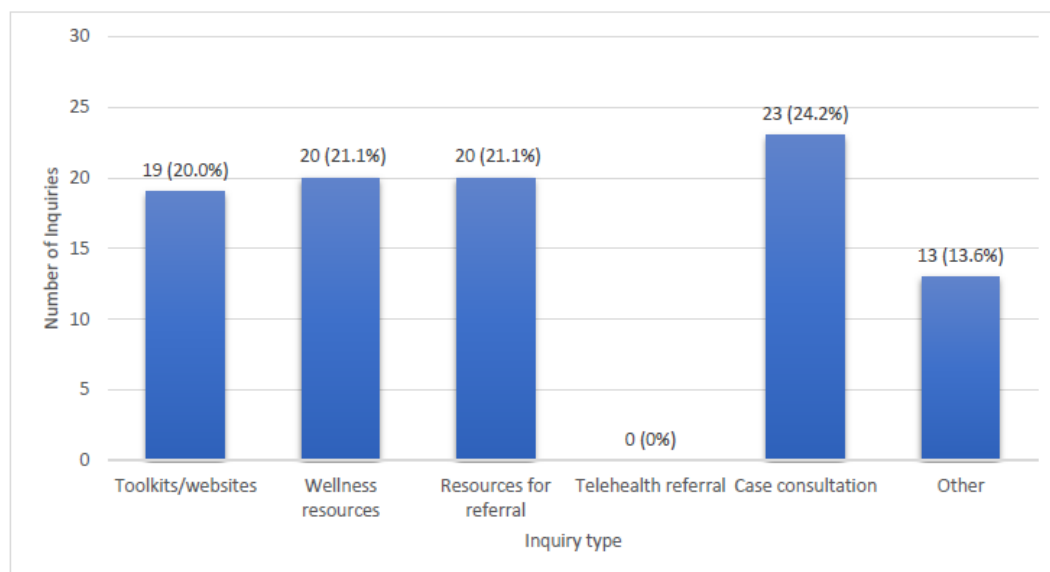
Kansas was awarded funding to establish a Pediatric Mental Health Care Access Program – a four-year (July 2019-June 2023) HRSA cooperative agreement. The Kansas program, KSKidsMAP to Mental Wellness promotes and supports integrating behavioral health into primary care through pediatric mental health care telehealth access programs. KSKidsMAP is a partnership between the Kansas

Department of Health and Environment and the University of Kansas School of Medicine-Wichita Departments of Pediatrics and Psychiatry and Behavioral Sciences.

Of the 105 counties in Kansas, 99 are designated as mental health professional shortage areas. This shortage leaves more than 70% of Kansas children with unmet mental health needs. Of those 99 mental health shortage areas, 23 have primary care physicians (PCPs) to fill the gap. To address this shortage, KSKidsMAP established a pediatric mental health care team, which includes board-certified child and adolescent psychiatrist, child and adolescent psychologist, pediatrician, and social work care coordinator. The KSKidsMAP team supports PCPs and clinicians in treating uncomplicated behavioral health issues within their clinical practice. To achieve this, a centralized telehealth network was established that includes a consultation line and TeleECHO Clinic.

KSKidsMAP Consultation Line: The consultation line is staffed weekdays from 8:00 am – 5:00 pm by a social work care coordinator. The care coordinator can assist PCPs by providing mental health and community resources, toolkits, best practice guidelines, referral information, and physician wellness recommendations. The care coordinator is also responsible for coordinating case consultations with the pediatric mental health team. When a case consultation is requested, the team reviews available behavioral health and psychiatric symptoms/concerns, meets with the PCP for a provider-to-provider consultation and makes recommendation for intervention treatment strategies. The PCP then provides care and treatment to the child/adolescent within their clinical practice. Since the soft launch in December 2019, the KSKidsMAP Consultation Line has received 95 inquiries (as of 4/28/2020). A breakdown of reasons for inquiry is included in the graph below (Figure 1).

Figure 1. KSKidsMAP Consultation Line Inquiries

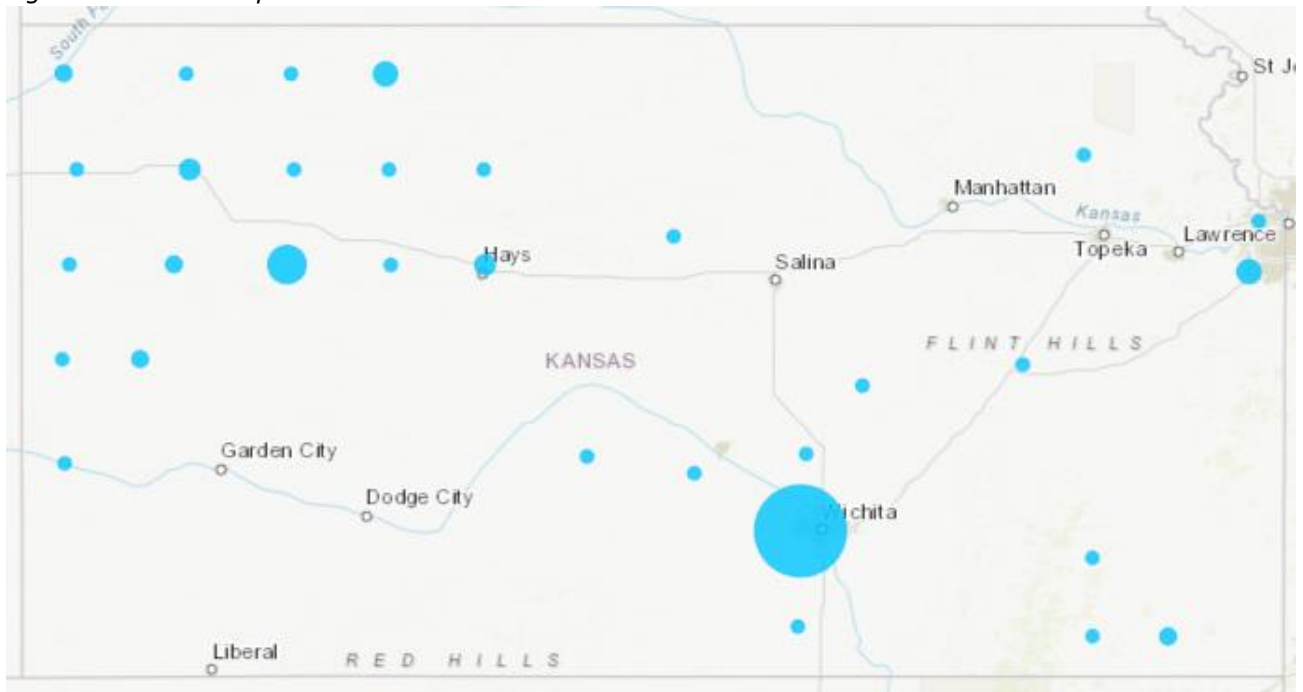


*Note: Telehealth referral is not yet active.

KSKidsMAP TeleECHO Clinic: The TeleECHO Clinic is enhancing primary care by moving knowledge, not patients, and aims to create an All Teach/All Learn environment for PCPs to learn how to provide the best care for children and adolescents with mental and behavioral health concerns. The KSKidsMAP team facilitates two virtual TeleECHO Clinic sessions a month and offers mentorship through the case-based learning, clinical discussion, and didactic learning to support knowledge in practice. Each

participant has opportunity to present a case and receive feedback and recommendations from other TeleECHO Clinic participants as well as the pediatric mental health “Expert Team”. Throughout the first year of the program, KSKidsMAP completed over 350 outreach activities across Kansas to share project goals, services, and enroll PCPs and clinicians to the program. During this time, KDHE collaborated with the REACH Institute to provide training to PCPs and clinicians on mental health care for children and adolescents in the primary care settings. A training cohort of 22 physicians and clinicians from different areas of Kansas were able to attend this three-day training. Participants also received 6-months of coaching calls where they could discuss how new training tools and strategies for addressing mental health in the pediatric and/or primary care setting influenced their practice and talked through barriers that may have surfaced through this process. The REACH coaching calls helped facilitate the development of the KSKidsMAP mental health care access provider network across Kansas. KSKidsMAP has enrolled over 70 PCPs and other clinicians into the program (Figure 2 and Table 1).

Figure 2. KSKidsMAP provider enrollment location



*Note: larger circles denote high numbers in the given area; map reflects the first 50 KSKidsMAP enrollees

Table 1. KSKidsMAP provider enrollment by type

Enrollee Type	N (%)
Physician/clinician	48 (67.1%)
Nurse Practitioner	15 (21.1%)
Physician Assistant	2 (3.0%)
Registered Nurse	1 (1.4%)
Psychologist	2 (3.0%)
Social Work	1 (1.4%)
Other	2 (3.0%)
Total	72 (100.0%)

*Note: table reflects the first all enrollees

As KSKidsMAP transitions to year two of the funding award, the program will continue its robust data collection efforts. The team anticipates the need for data demonstrating program effectiveness for sustainability strategy discussions. KSKidsMAP is seeking support, ideas, and partnerships for exploring sustainability opportunities for the future.

Lessons Learned from COVID: Concerns & Recommendations for Next Year

- Telehealth: A Tool to Be Used Intentionally to Meet Changing Needs
 - A wonderful alternative to Face-to-Face services, during stay at home orders, etc. but not a substitute. Science is clear about the power of relationship and we cannot replicate that by electronic means.
 - Is a tool that can have a place in an array of services creating a continuum of care ultimately leading to competent social interactions between people face-to-face
 - We have seen an increase in MH services for some populations, but in general a decrease in the duration of a unit of service.
 - We have also seen a decrease in services for some populations.
 - Providers have seen new challenges and limited ability to protect the confidentiality of services.
 - In some instances, Telehealth should be continued after pandemic:
 - Increased access to some services, including specialized or specific services, when there is none/limited (for example: no psychiatrist, no/limited availability of therapists that specialize in certain childhood topics such as human trafficking, sex abuse, substance use services, etc.)
 - Some people have very poor ability or great fears of interpersonal interactions and telehealth might be a bridge
 - Distance is always an issue in Kansas as many of our parents do not have cars or other resources to bring kids to treatment
 - It could also ease follow up with some clients that cannot come to their provider/center in between visits
 - Not a replacement but a supplement, and in some instances an augmentation of services (i.e. parent visits)
- Unemployment and the impact on children and families and behavioral health
- Increase in ACE scores/trauma
- Increased risk of abuse and neglect for vulnerable populations
- We believe we need to be constantly vigilant regarding the impact of COVID on provider capacity. For example, how will the impact of personal choice during personal time of staff members impact the number of COVID cases, and the resulting impact on organizational capacity, including available PRTF beds and the waiting list.

We have heard many positive benefits from the use of telehealth during the COVID pandemic in delivery of behavioral health services. We believe the data could be used to develop protocols and best practice recommendations for delivering behavioral health services using this method.

Recommendations:

1. Continue allowing use of telehealth codes and processes that were created so that we can gather some data and further study the use of these processes.
2. The state should work with stakeholders to develop a protocol(s) to identify when to use telehealth or not.
 - Protocols include considerations of confidentiality and potential impact on care.
 - The protocols should include a recommended method (and resources) for evaluation

Resources:

Hazelden Betty Ford Foundation: Telehealth for Addiction Treatment and Recovery:
https://www.hazeldenbettyford.org/education/bcr/addiction-research/telehealth-addiction-treatment?utm_source=clinical-connection&utm_medium=email&utm_campaign=72857

2020-2021 Goals

1. Further explore telehealth and make recommendations about its use related to behavioral health services: during a pandemic and under regular circumstances.
2. The impact of COVID has affected children and families differently. We will look beyond the initial distress and treatment, to make recommendations regarding the need to increase family/community protective factors, like resiliency and connectedness.
3. Discuss racial disparities and cultural considerations related to behavioral health services in Kansas.
 - a. Request and review state data to determine if there are racial disparities in access to care. Based on findings, there could be recommendations around outreach, stigma reduction efforts, etc.
 - b. Review the Culturally and Linguistically Appropriate Services (CLAS) standards that are required for cultural awareness staff training, and consider possible recommendations.
4. Use dedicated time during meetings to discuss the KSKidsMap project, and more intentionally serve as an advisory group.

**GBHSPC
CHILDREN'S SUBCOMMITTEE
CHARTER**

GBHSPC SUBCOMMITTEE CHARTER	
Subcommittee Name:	Governor's Behavioral Health Services Planning Council Children's Subcommittee
Context:	The Children's Subcommittee generates recommendations for the GBHSPC regarding the behavioral health system of Kansas as it relates to Kansas children and their families. The GBHSPC reviews not just this subcommittee's recommendations but other existing subcommittees and presents all Behavioral health recommendations to the Secretary of KDADS and the governor. It is acknowledged that although the priority focus of the GBHSPC are the SPMI and SED target populations (Federal Law 102-3210, the work of the subcommittee is to be conducted with the whole system and all Kansas citizens with behavioral health needs in mind
Purpose:	The Children's Subcommittee is devoted to the behavioral health needs of children and their families. The subcommittee examines and makes recommendations to improve the array of behavioral health services offered to children and their families through Kansas Community Mental Health Center (CMHC), substance use treatment providers other children service systems and collaboration between systems of care such as Psychiatric Residential Treatment Facilities (PRTF), hospitals, juvenile justice services and schools. We: <ul style="list-style-type: none"> ● Identify strengths and needs. ● Make informed recommendations. ● Use subcommittee member networks to address identified needs and influence change.
Vision:	That all Kansas children and their families will have access to essential, high-quality behavioral health services that are strengths-based, developmentally appropriate, and culturally competent.
Mission:	To promote interconnected systems of care that provide an integrated continuum of person and family centered services, reflective of the Children's Subcommittees Vision and Values: <ul style="list-style-type: none"> ● <u>Interconnected Systems:</u> The integration of Positive Behavioral Interventions and Supports (PBIS) and School Mental Health within school systems to blend resources, training, systems, state, and practices in order to improve outcomes for all children and youth. ● <u>Systems of Care:</u> A spectrum of effective community based services and supports that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses cultural and linguistic needs to enhance functioning at home, in school, in the community and throughout life.

	<ul style="list-style-type: none"> ● <u>Integrated Services:</u> Integrating mental health, substance abuse and primary care services produces the best outcome and proves the most effective approach to caring for people with multiple needs. ● <u>Continuum of Care:</u> <ul style="list-style-type: none"> ✓ Across the Lifespan – From birth to age 22 ✓ Across levels of Intensity – Preventative (Tier 1), target (Tier 2), Intensive (Tier 3). ● <u>Person & Family Center Planning:</u> A collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible. Person and family-centered treatment planning is care planning that is strength-based and focuses on individual capacities, preferences, and goals. Individuals and families are core participants in the development of the plans and goals of treatment.
Values:	<p>The Children’s Subcommittee will use the following Values to guide their purpose:</p> <ul style="list-style-type: none"> ● Use data from multiple sources to ensure an accurate picture of the target population. ● Promote person and family-centered planning. ● Ensure all recommendations are supported by evidence. ● Maintain collaborative and inclusive networks. ● Listen and respect the voices of those we serve.

Governor's Behavioral Health Services Planning Council
Subcommittee for Children's Mental Health
Members
May 2020

- ◆ Erick Vaughn, *LMSW, Chair, Executive Director, Douglas County CASA*
- ◆ Myron Melton, *Vice Chair, Education Consultant, Special Education and Title Services Team, Kansas*
- ◆ Laura Hattrup, *LSCSW, Secretary, State Trainer, Kansas Technical Assistance System Network*
- ◆ Nancy Crago, *LSCSW, Past Chair, Director of Psychosocial Rehabilitation, Family Service and Guidance Center*
- ◆ Anthony Bryan, *Director of Risk Management and Corporate Compliance, Family Service and Guidance Center*
- ◆ Sandra Berg, *Executive Director, UnitedHealth Group*
- ◆ Brenda Grove, *Parent Representative, Governor's Behavioral Health Services Planning Council Liaison*
- ◆ Charlene Jostes,
- ◆ Kellie Hans-Reid, *Foster Care Coordinator, Aetna Better Health of Kansas*
- ◆ Kelsee Torrez, *Maternal & Child Health Behavioral Health Consultant, KDHE*
- ◆ Melinda Kline, *Prevention and Protection Services Deputy Director, DCF*
- ◆ Natalie Sollo, *Director of Ambulatory Division, KUMC Pediatrics*
- ◆ Rick Gaskill, *Executive Director, Sumner Mental Health Center*
- ◆ Robert (Bobby) Eklofe, *MHSA, Vice President of Behavioral Health Operations, KVC Hospitals, Inc.*
- ◆ Jeff Butrick, *Service Manager, Kansas Department of Corrections-Juvenile Services*
- ◆ Kevin Kufeldt, *LCPC, Program Manager, ACT Residential Treatment, Johnson County Mental Health*
- ◆ Cheryl Rathbun, *Chief Clinical Officer, Saint Francis Community Services*
- ◆ Chelle Kemper, *Special Education Director*
- ◆ Jacob Box, *Parent Representative, Governor's Behavioral Health Services Planning Council Liaison*
- ◆ Joe Winslow, *KDADS Liaison, Kansas Department for Aging and Disabilities Services, Children's Program Manager*
- ◆ Gary Henault, *KDADS Liaison, Kansas Department for Aging and Disabilities Services, Children's Program Manager*
- ◆ Charlie Bartlett, *KDADS Liaison, Kansas Department for Aging and Disabilities Services, Special Projects*
- ◆ Sherri Luthe, *Parent Representative*