

# A Children's Mental Health System of Care: An Agenda For Change



# New York State Coalition for Children's Mental Health Services

The New York State Coalition for Children's Mental Health Services (the Coalition) is a 501c (3) organization dedicated to the advancement of children's mental health services in New York State. The Coalition represents the interests of children and youth, family members and providers who seek to inform and educate policymakers about the need for a comprehensive children's mental health system of care.

## ACKNOWLEDGEMENTS

### OUR MISSION

*To promote quality mental health services for New York's children with serious emotional disturbance and their families by leading the service provider community in identifying effective practices and participating in planning and implementing a continuum of services that are family-focused, comprehensive, cost-effective, culturally responsive, coordinated and appropriately funded.*

This report was developed by the New York State Coalition for Children's Mental Health Services and is the result of the work of committed individuals to the children's mental health system of care. Under the leadership of the following individuals, discussions were held and consensus was reached on issues most pertinent to transforming the children's mental health community. As the guiding forces behind the development of this paper, the following individuals and the organizations they represent actively support and affirm the recommendations herein.

The New York State Coalition for Children's Mental Health Services extends appreciation to **Clyde Comstock, Hillside Family of Agencies** as primary author of this report.

*Special thanks to the following individuals for their expertise in developing this report.*

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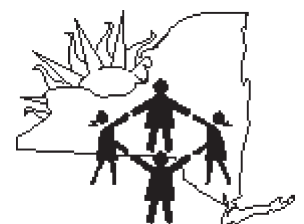
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This paper, developed by the New York State Coalition for Children’s Mental Health Services, represents the next step in advocating for the creation of a comprehensive, coordinated mental health system that is responsive to the many needs of our children and families in New York State. Under the leadership and partnership of policymakers, family members, providers, children and youth, New York can bring fundamental transformation to our children’s mental health system. This transformation must be built upon prevention and wellness; strengthening of families; competencies of the workforce; evidence-informed practices and measurement of outcomes.

In 2003, the NYS Coalition of Children’s Mental Health Services produced a white paper entitled, “A Children’s Mental Health System of Care Blueprint ” which articulated a vision that set a clear direction and crafted a new future for the children’s mental health system. We believe the paper enhanced policy discussions and decisions governing the provision of children’s mental health services and care. Through strategic focus and ongoing dialogue the Coalition’s policy work continues to reflect a common goal - to advance the social and emotional well-being of New York’s children. This report updates the original blueprint and advances a change agenda intended to keep up the momentum already generated in the development and operation of promising policy and service approaches during the next few years.

In New York State, we have experienced tremendous growth and an unprecedented focus on programs and services, such as Child and Family Clinic Plus, offered in the children’s mental health system of care. A unified consensus is present that mental health is fundamental to the overall health and well-being of our children. And, with the passage of Timothy’s Law, mandated mental health parity has become a reality for New York’s adults and children. These efforts must continue until the prevalence of adverse childhood experiences is condensed and the antidote of early intervention and immediate access is applied.

In addition to continuing the development of positive mental health services in traditional mental health settings and normative settings, there is also a need to consider the overlap and complex interrelationships between New York State’s children’s systems of care: mental health, child welfare, developmental disabilities, substance abuse, and realistically, education.

*“The prevalence of adverse childhood experiences and their long-term effects are clearly a major determinant of the health and social well-being of the nation. This is true whether looked at from the standpoint of social costs, the economics of health care, the quality of human existence, the focus of medical treatment, or the effects of public policy.”* **The Origins of Addiction: Evidence from the Adverse Childhood Experiences Study. V. Felitti, MD**

And, while continuing to grow and enhance services that support the children’s mental health community, it is apparent that an insufficient amount of data collection and research has been conducted in the field of children’s mental health. The time is now to build and improve the data capacity at the practice level and to improve the system’s capacity for tracking meaningful, achievable outcomes across children’s mental health services and programs.

To further this transformation, we must continue to partner collaboratively and work toward achieving the Coalition’s original mission statement “...a continuum of services that are family-focused, comprehensive, cost-effective, culturally responsive, coordinated and appropriately funded.” This document is a promising response to the challenges and opportunities presented to New York’s children’s mental health system. It offers a set of values which will frame future discussions and decisions to advance the transformation of the system. To this end, a series of action steps, policies and recommendations are provided to encourage a timely and relevant discussion of the future of New York’s mental health system for children and their families.

# A Children's Mental Health System of Care: An Agenda For Change

## VALUES & ACTION STEPS

### **I. MENTAL/EMOTIONAL WELLNESS OF CHILDREN AND THEIR FAMILIES IS A PRIMARY PUBLIC HEALTH ISSUE.**

Much as the State's public health system has initiated campaigns to address issues of preventing diseases through its immunization program, attempted to reduce the incidents of smoking through its public education program, and inform the public of early signs of autism, New York's mental health system needs to "normalize" mental wellness as an entitled and valued component of good health. It must do this through adequately funded public education, prevention, and early identification efforts. These efforts have begun in earnest with an important new program, "Child and Family Clinic Plus". This is especially important since it focuses on children who will have to deal with mental illness for a very long time if their issues are not addressed early. The mental health system in the past has been heavily focused on treatment after serious mental illness has manifested itself. However, the deleterious effects of adverse childhood events and the impact of trauma on the future mental health status of our children and youth underscore the value of placing greater emphasis on prevention and early identification. In addition, the value of mental wellness must be integrated into the array of mental health services provided for those children identified in need of mental health services. The mental health system in New York has made significant progress over the past several decades providing a broader array of community-based mental health services that are more accessible and effective. The focus on mental wellness would accelerate the direction in which New York State is heading.

### **ACTION STEPS**

#### **A. Market Mental/Emotional Wellness**

Create and implement a public marketing plan that utilizes a primary public health approach to reduce stigma and fuel a statewide commitment to promoting mental/emotional wellness, including resiliency and protective factors, for all New York's children and families. This should be accomplished through the joint efforts of the New York State Office of Mental Health, Department of Health, State Education Department, Office of Children and Families, commercial insurance providers, service providers, and families.

#### **B. Develop Preventive Services**

Identify viable prevention models (including a focus on early childhood brain development), early intervention models, and developmentally appropriate screening tools and add them to the mental health system of care across the state.

## 2. MENTAL HEALTH SERVICES SHOULD BE AN ENTITLEMENT FOR CHILDREN AND FAMILIES.

New Yorkers should expect that the mental health needs of their children and families should be as high a priority as their educational, safety, and other health needs. Currently, children and families receive mental health services if the mental health system has those services available. In many areas, necessary services do not exist or there are long waiting lists for those services. On the other hand, schools cannot refuse to educate children because of lack of capacity and county departments of social services cannot refuse to serve neglected or abused children. The children's mental health system must take similar responsibility to ensure that the full array of culturally competent services is available to all children and families across New York State when they need them. This array should reflect the cultures of the children and families receiving services. As New York's population becomes increasingly diverse, it becomes more necessary that we understand the cultural and socioeconomic circumstances of the different population groups in our society. Understanding the context of people's lives, which must include their ethnicity, religion and race, is a respected value in providing effective treatment. This culturally competent service array should be equally available to children with and without families.

### ACTION STEPS

#### A. The Mental Health System Is Responsible For Cross-system Youth With Mental Health Challenges

Youth with mental health challenges are the responsibility of the mental health system even when those youth are "cross-system" or in another public child serving system. Mental health must partner with other child-serving systems to help solve the service needs of those youth and should participate in the funding of pilot models that propose solutions to the cross-systems challenges.

#### B. Identify And Fill Service Gaps

As service gaps are identified, either because there is insufficient capacity to meet referral needs or because a population has emerged with a mental health challenge for whom there are no effective services available, OMH should fill those gaps.

#### C. Rebuild Service Models

A process should be put in place that ensures that existing service models are regularly reviewed to ensure that the service design and staffing design meets current needs.

#### D. Teach The Community How To Access Services

Provide training to communities (school districts, counties, families, providers etc.) about what services exist in the mental health system and how they are accessed. Partner with other state agencies to also provide training on the rest of the child-serving system to increase understanding across all of the systems.

#### E. Ensure That Timothy's Law Continues

Parity is a critical element in allowing families access to the mental health services they need.

#### F. Address Workforce Diversity

The mental health workforce should look like the populations who receive service. The specific action recommendations are covered in the Qualified Workforce section.

### 3. FAMILY STRENGTHENING IS KEY TO THE SYSTEM OF CARE.

*Family strengthening is defined as “a deliberate and sustained effort to ensure that parents have the necessary opportunities, relationships, networks, and supports to raise their children successfully, which includes involving parents as decision-makers in how their communities meet family needs.”*

– **Annie E. Casey Foundation**

Children are best raised in families. Our mental health service system, jointly with families, must work diligently to ensure that they receive the support they need to effectively accomplish that key function. If families are unable to parent their children, we must actively work with the other systems to find forever families for every child. Family strengthening also empowers families to become sophisticated clinical partners in the treatment of their children and to effectively participate in the design of the service system itself.

#### **ACTION STEPS:**

##### **A. Families Drive Service Planning**

Families must drive the service planning for their children, across levels of care, and across funding streams with close cooperation and consultation from service providers.

##### **B. Help Families Develop Advocacy Skills**

Service providers, county, and state government must each support and assist the families in developing and exercising their skills in service planning and advocacy.

##### **C. Engage Families At The System Level**

Families and youth must also be full partners in the design and operation of the system in which they are served.

##### **D. Formalize And Fund The Parent Intervention Model**

Parents who are employed to provide support to other families has emerged as a new discipline. Consequently:

Clear roles and responsibilities for families should be defined and promulgated at the state and county level.

Culturally responsive family support should become part of each service model package with parent staff focusing on family strengthening.

A defined system wide standard should be developed for family involvement service and should be adhered to by all providers.

Models of evidenced based training should be identified and extensive training be provided to counties, regions, families and providers that delineates the power and possibility of family and youth involvement in service planning.

##### **E. Ensure That Every Child Has A Forever Family**

The mental health system should work cooperatively and aggressively with the other child serving systems to find families for all children and youth in the mental health system who are freed for adoption. Mental health services should then help support the success of the new family.

#### 4. **THE 18 TO 25 YEAR OLD POPULATION NEEDS SERVICES SPECIFICALLY DESIGNED FOR YOUNG ADULTS.**

This group of youth has quite specific needs that cannot be effectively met when they are mixed into the adult system. The young adult group requires a person-centered array of services in basic areas: education, vocational training, adaptive and social skills training, health and mental health services, and self-advocacy skills.

##### **ACTION STEPS**

###### **A. Develop Models**

Continue to partner with the Coalition for Children's Mental Health to identify and support the promising practices and general models that can improve the delivery of services as youth transition from the children's system.

#### 5. **A QUALIFIED WORKFORCE IS REQUIRED TO PROVIDE THE SYSTEM OF CARE.**

As the delivery of services has become increasingly complex, the need for a high-quality, stable workforce has never been more evident. We must increase our efforts to ensure that we are able to attract and retain all staff, but in particular, child psychiatrists, registered nurses, mature direct care staff and seasoned clinicians. In order for a qualified workforce to successfully serve a diverse population, the workforce must look like the populations served. In particular, the mental health workforce must attract people of color to the field.

##### **ACTION STEPS**

###### **A. Set Market-based Salaries**

Ensure that salary models promulgated by OMH allow market-based salaries that can attract qualified workers into the mental health system.

###### **B. Ensure Highly Trained Staff**

High quality training should be provided to new staff and existing staff to ensure their success in working with youth and families. Rate structures must support the provision of training and the staffing necessary to allow personnel to attend the training. The training should be developmental and move staff along the beginner to expert continuum.

###### **C. Develop Succession Plans**

Organizations should develop succession plans to ensure continuity as increasing numbers of retirements take place.

###### **D. Institute A Scholarship And Loan Forgiveness Program**

This program would assist in the development of a diverse workforce through the addition of scholarships for continuing education, staff training and professional development. The scholarship fund should include undergraduates, graduate students in social work and psychology, and child psychiatry.

###### **E. Attract A Diverse Workforce That Reflects The Service Population**

Mental health treatment is heavily based on a full understanding of the consumer population in the context of their lives. Given the increasing diversity of our population and the changing immigration patterns in New York, being able to attract staff who reflect these demographic shifts will add to our capacity to engage families, build trust quickly, and understand how interventions can be more effective.



**6. EVIDENCE-INFORMED PRACTICE ENHANCES THE OUTCOMES OF THE SYSTEM OF CARE AND MUST BE DEVELOPED THROUGH PARTNERSHIP BETWEEN GOVERNMENT, THE RESEARCH COMMUNITY, AND PROVIDERS.**

There has been an insufficient amount of research conducted in the field of children’s mental health. Most of the research that has been done has been carried out in tightly structured research settings. While this research is important to our collective learning, there is an insufficient connection of the research to the actual populations and settings where our children and families are treated. Consequently, there needs to be increased knowledge transfer between the research settings and the field applications. Additionally, the research needs to be extended into the application settings in communities across our state to ensure that the evidence-base being gathered is actually effective with New York’s children and families.

### **ACTION STEPS**

#### **A. Build A Research Partnership With Providers, Researchers, And Government**

Develop a partnership between government, the research community and providers with the goal of creating a stronger research to practice link. NYSOMH should work with the NYS Coalition of Children’s Mental Health Services to develop a workgroup that systematically addresses all the issues providers face with collecting outcomes and implementing EBP in their practice settings. The workgroup should include OMH staff, providers and representatives of the research committee. The work group should be prepared to identify and propose solutions for fiscal, programmatic and staffing concerns.

#### **B. Build Data Capacity At The Practice Level**

Improve the capacity of providers to collect data and to analyze outcomes for their programs. This improved capacity must include a comprehensive list of acceptable outcome measures that are empirically sound yet diverse enough to adequately measure outcomes for multiple domains of interest (e.g., “at home, in school, and out of trouble”) and to provide meaningful clinical information to disparate treatment contexts.

#### **C. Create A Statewide Plan To Track Outcomes**

NYSOMH must collaborate with providers to develop a unified, achievable plan to improve the system’s capacity for tracking meaningful outcomes across program types. This plan should include improving the capacity of providers to collect data and to analyze outcomes for their programs and reimbursement structures should support the plan. This plan should work in cooperation with the other tracking systems used by the other child serving systems that the voluntary agencies must implement.

The vision for change to the children’s mental health system of care is intended to support a widely stated and agreed upon message about children’s mental health services:

*“Children and youth with mental health needs and their families will thrive at home, at school, in the community, and throughout their lives, when their resilience is fostered and appropriate services are provided.”*

Our on-going efforts will focus on strategic initiatives encouraging policy and practice transformation of the children’s mental health system of care and expanding the range of diagnostic-appropriate services. Our goal is to ensure that every intervention offered to children and families is designed to support their success in the community. Therefore, whether services are provided in residential or community-based settings, all stakeholders will work toward one common goal - providing children with the opportunity to rejoin their communities and lead productive lives.

The Coalition will continue to articulate our strategic initiatives and action steps until the disparity between children who need services and who receive them is addressed. Research indicates that 79% of children 6-17 years-of-age who are in need of mental health services do not receive them (Kataoka, Zang, & Wells, 2002) and also has demonstrated that children can recover quickly from emotional challenges

when treated effectively. The initiatives and actions recommended in this paper reflect the need for children and families to access care and treatment and AFFORD care and treatment. To support these initiatives efforts will continue to urge mental health parity in both access and reimbursement.

The Coalition will actively support policies that reflect the family voice, encourage wide-spread family representation and provide avenues for parental success when they seek assistance for their children. Parents can usually identify and attend to their child’s physical needs – food, shelter, rest, physician and dental care, activities and companionship. However, attending to a child’s mental health and emotional needs is not easy or straightforward. Currently, parents seeking professional help for the social or emotional well-being of their child will not find a standard set of instructions. This must be addressed and changed to improve outcomes. Families are the essential ingredient in success.

*“The essential contribution of family connectedness to promoting adolescent health was demonstrated clearly and convincingly at the end of the millennium, largely through the National Longitudinal Study on Adolescent Health. Findings from this national survey...indicated that for adolescents, family connectedness was protective against emotional distress, suicidal thoughts and behaviors, violence, cigarette use, alcohol use, marijuana use, and young age at sexual debut.”*

The Association Between Adverse Childhood Experiences and Adolescent Pregnancy, Long-Term Psychosocial Consequences, and Fetal Death. S. Hillis, R. Anda, S. Dube, V. Felitti, P. Marchbanks, J. Marks, *Pediatrics* V.113, N.2, Feb. 2004

Untreated mental health issues WILL have long-term adverse effects on the lives of children and their families. Without treatment, children with mental health issues are at increased risk of school failure, dependence on social services, contact with the criminal justice system, alcohol and substance abuse and an array of adverse health indicators. In order to adequately address the shortage of services and the rationing of children's mental health services, we must focus our efforts on resiliency, recovery and success.

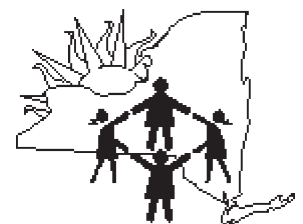


Recent, valuable enhancements to New York's mental health system of care include Child and Family Clinic Plus, a ground-breaking screening program that will allow for early intervention and treatment. Continued expansion of OMH's Home and Community Based Waiver program is enhancing nearly 3,000 families' ability to access care for their children while they remain at home. Another promising New York initiative is the Bridge to Health (B2H) program for children who have been in foster care and have mental health needs. B2H will allow children and their families (biological, foster or adoptive) to receive wrap-around services with an on-going, community-focus up to age 21.

Unfortunately, we also know that evolving amendments to federal Medicaid rules are going to affect the future of children's clinic services, case management services, day treatment services and possibly, residential services. As the activities that are eligible for federal financial participation become more limited, the ability to creatively individualize care will also become more restricted. In addition, we may be forced to reduce the array of services temporarily until new financing mechanisms are developed or existing financing mechanisms, such as state dollars or insurance coverage and rates, are expanded.

As these challenges are addressed, we believe a well-articulated message will serve to encourage policy and fiscal decisions:

*“Children and youth with mental health needs and their families will thrive at home, at school, in the community, and throughout their lives, when their resilience is fostered and appropriate services are provided.”*



“The CASSP principles have become the foundation for system of care initiatives ... values built upon these principles must guide our efforts to transform the current array of services to a true system of care.”

## Child and Adolescent Service System Program (CASSP)

### **Brief History**

A national study in 1982 found that two-thirds of all children with severe emotional disturbances were not receiving appropriate services. These children were “unclaimed” by the public agencies responsible to serve them, and there was little coordination among the various child-serving systems. To address this need, Congress appropriated funds in 1984 for the Child and Adolescent Service System Program (CASSP), envisioned as a comprehensive mental health system of care for children, adolescents and their families.

### **CASSP Core Principles**

CASSP is based on a well-defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. These principles are summarized in six core statements.

**Child-centered:** Services meet the individual needs of the child, consider the child’s family and community contexts, and are developmentally appropriate, strengths-based and child-specific.

**Family-focused:** Services recognize that the family is the primary support system for the child and participates as a full partner in all stages of the decision-making and treatment planning process.

**Community-based:** Whenever possible, services are delivered in the child’s home community, drawing on formal and informal resources to promote the child’s successful participation in the community.

**Multi-system:** Services are planned in collaboration with all the child-serving systems involved in the child’s life.

**Culturally competent:** Services recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of the child’s and family’s ethnic group.

**Least restrictive/least intrusive:** Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.



## CHANGES BY PROGRAM IN UNITS OF SERVICE RECEIVED BY INDIVIDUALS UNDER THE AGE OF 18

*Reported in the Patient Characteristics Surveys (pcs) of 1999, 2001, and 2005*

NYS Office of Mental Health conducts the Patient Characteristics Survey every two years, and describes it as "...a comprehensive one-week 'snapshot' of the population served by New York State's public mental health system and the services they receive." It is available on the OMH website under "Statistics and Reports."

The PCS includes data on about 75 separate services, about 50 of which are used by 5 or more individuals under the age of 18. The charts below present PCS statistics for modalities of care provided by the New York State Coalition for Children's Mental Health Services, as well as others considered important by virtue of the numbers of children served.

### CHART 1: SERVICE CATEGORIES

**Service Categories**                      **Units of Service During Survey Period**                      **% Change**

	1999	2001	2005	1999/2005
Community Support	3919	5019	6894	+ 75.9
Inpatient	2027	2162	2103	+ 3.7
Outpatient	25023	24076	24794	< 1.0
Emergency	850	1027	827	- 2.7
MH Residential	565	662	498	- 11.8

### CHART 2: SPECIFIC SERVICES

**Services**                                      **Units of Service During Survey Period**                      **% Change**

	1999	2001	2005	1999/2005
School Based	132	345	599	+ 353.7
HCBW	142	421	489	+ 244.0
Family Support	706	988	992	+ 40.5
Community Residence	135	133	174	+ 28.8
Day Treatment	2594	2785	3018	+ 16.3
ICM/SCM	1638	1825	1843	+ 12.5
RTF	463	486	482	+ 4.0
Family Based Treatment	248	246	237	< 1.0
All Hospital	1679	1707	1644	- 2.0
Outpatient Clinic	22262	21180	21714	- 2.5

## OBSERVATIONS FROM THE OMHPCS OF 1999, 2001 & 2005

Looking at multiple PCS's gives us a chance to see how the public mental health system has actually changed over time, because of—or perhaps in spite of—our stated plans and goals. It provides a valuable wide-lens perspective.

If in 1999 we intended to reduce the profile of expensive institutional care and increase that of community-based activity, we appear to have been very successful. Of the five major areas of service, only one—"Community Support"—was significantly larger in 2005 than it was in 1999, but the growth there was robust; the category's 76% expansion allowed 2,975 more children/youth to receive care in one or more of the category's 37 services.

"Community-based" includes schools as well as homes: school-based services increased by 350%, adding 467 new clients. Day Treatment extended care to 424 additional student/clients. Care delivered with direct reference to families also grew significantly: HCBW added 347 slots, Family Support another 286, and the ICM/SCM combination increased service by 205 children and their families.

It is difficult not to speculate about the relationship between the expansion of work done in "lower levels" of care and the flat or declining profiles of high-intensity/high expense modalities; e.g., the Mental Health Residential category went down almost 12%, Emergency Care by nearly 3%, and Inpatient Care was basically flat. We would like to believe that the deployment of a diversified but integrated family- and community-based infrastructure will reduce our dependence on more intense levels of care; time and more data will determine if this is actually what is happening.

At least two areas of concern deserve our attention. Outpatient clinic care decreased slightly (-2.5%). Despite the decrease in clinic patients, clinics remain far and away the most likely site a child or youth will receive public mental health care in New York State. Clinics provided 21,714 units of service during the survey week—66.5% of all care offered by the entire system. We spoke about the importance of outpatient clinics in our 2003 Blueprint, and since then OMH has rolled out the promising and very exciting Child & Family Clinic Plus initiative. Scarcely one year into Child & Family Clinic Plus, however, we are confronted by the threat of federally-initiated financial restructuring in this area. We must, therefore, for different reasons than we had in 2003, renew the call for close attention to child and family outpatient clinics.

Finally, the serious situation in the area of cross-systems activity is clearly described in the 2005 PCS. On the PCS Table 4.A, "Clients Served...by Current Residence", we find that only 672 Foster Care children—out of a state population in the neighborhood of 25,000—were being served in any of the 50 child and family services during the survey week. Add an additional 266 individuals from institutional settings and community residences, and we still have a total of only 938 youth receiving care during the survey week, surely far too few for a population that is by definition multiply afflicted. This is another area where we hope to see dramatic improvement.

## NOTES

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