Children’s Behavioral Health: Charting a Path to the Future

Michelle Zabel, MSS
Assistant Dean, UMB School of Social Work
Director, The Institute for Innovation and Implementation &
National Technical Assistance Network for Children’s Behavioral Health
(TA Network)
What Makes Up NTTAC?

Development and Implementation of TA and Related Materials/Activities to Support States and Communities Funded by the Comprehensive Community Mental Health Services for Children and Their Families Program

Logistical and Administrative Support for the CMHS for Children and Their Families Program and TA for American Indian/Alaska Native Populations

National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC)
TA Network Partner Organizations

- Institute for Innovation & Implementation, University of Maryland School of Social Work
- Case Western Reserve University (CWRU)
- The Center for Health Care Strategies, Inc. (CHCS)
- The Family-Run Executive Director Leadership Association (FREDLA)
- Georgetown University Center for Child and Human Development Center (GUCCHD)
- Human Service Collaboration (HSC)
- Management & Training Innovations (MTI)
- The National Indian Child Welfare Association (NICWA)
- Tufts Medical Center (Tufts)
- Policy Research Associates (PRA), National Center for Mental Health and Juvenile Justice (NCMHJJ)
- Portland State University (PSU)
- The University of South Florida (USF), College of Community and Behavioral Health Science, Department of Child and Family Studies (CFS)
- The University of Washington (UW)
- Youth M.O.V.E. (Motivating Others through Voices of Experience) National (YMEN)

“The world that we have made as a result of the level of thinking we have done thus far creates problems that we cannot solve at the same level at which we created them.”

Albert Einstein

Historic & Current System Problems

- Lack of home and community-based services and supports
- Deficit-based/medical models, limited types of interventions
- Lack of partnerships with families and youth
- Lack of attention to cultural differences
- Limited service options (inpatient, outpatient, residential)
- Providers not skilled in evidence-informed practices
- Cost
- Rapid financing structures
- Administrative inefficiencies
- Knowledge, skills, and attitudes of key stakeholders
- Lack of individualized interventions tailored to each child and family
- Poor outcomes
- Knowledge, skills, and attitudes of key stakeholders
- Overuse of excessively restrictive settings
- Patterns of utilization resulting in/leading to disproportionate and disparities
What do the data say?

Did You Know?

An estimated 1 in 10 youth meets SAMHSA criteria for a Serious Emotional Disturbance (SED), defined as a mental health problem that has a significant impact on a child’s ability to function socially, academically, and emotionally.

Among children aged 10 to 14 in 2016, death by suicide was more common than death from traffic accidents.

50% of adult mental illness manifests by the age of 14; 75% by the age of 24.

It is estimated that 20% of children and adolescents have a diagnosable mental, emotional, or behavioral disorder costing the public $247 billion annually.

Major depression, which can be life-threatening, affects 12% of adolescents, with as many as 20% of young people experiencing at least mildly depressive symptoms.

An estimated 13-20% of children in the United States (up to 1 out of 5 children) experience a mental disorder in a given year.

In 2013, an estimated 21.6 million persons aged 12 or older (8.2%) were classified with substance dependence or abuse in the past year.

Mental Health: Costliest Health Condition of Childhood

- Mental Health Disorders
  - Asthma
  - Trauma Related Conditions
  - Acute Bronchitis
  - Infectious Diseases

Mental Health Disorders are the **MOST** Expensive Conditions in Childhood

- While children who receive mental health services are less than 10% of the overall Medicaid child population, they account for 38% of all Medicaid child expenditures (Pires, Grimes, Allen, Gilmer, & Mahadevan, 2013).

- The highest expenditures for all types of insurance and conditions (including physical conditions) among children 0 to 17 were for the treatment of mental disorders, costing **$13.8 billion** in 2011 (AHRQ, 2015).

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Poor Outcomes for Children, Families & Systems

Severe behavioral and emotional problems
School dropout
Substance use
Suicide
Poor vocational success
Correctional system involvement
Inability to live independently
High financial costs across child-serving systems
High social costs to families and society

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The Costs Of A Poor Response

Emotional, behavioral and MH disorders in childhood/adolescence associated with:

- School dropout: estimated cost to society: $292,000 for each dropout over their lifetime

- Substance abuse: estimated cost to society: $740 billion annually in costs related to crime, lost work productivity and health care
  [https://www.surgeongeneral.gov/initiatives/healthier-numbers/#supplemental-references-for-economic-costs](https://www.surgeongeneral.gov/initiatives/healthier-numbers/#supplemental-references-for-economic-costs)

- Criminality: estimated costs to society of a ‘life of crime’:
  $1.3million - $1.5million
Children and Youth with Serious Behavioral Health Conditions Are
A Distinct Population from Adults with Serious and
Persistent Mental Illness

- Do not have the same high rates of co-
morbid physical health conditions.
- Have different mental health diagnoses
  (ADHD, Conduct Disorder, Anxiety; not so
  much Schizophrenia, Psychosis, Bipolar as
  in adults), and diagnoses change often.
- Are multi-system involved — two-thirds
  typically are involved with CW and/or JJ
  systems and 60% may be in special
  education — systems governed by legal
  mandates.
- Coordination with other children’s systems
  (CW, JJ, schools) and among behavioral
  health providers, as well as family issues,
  consumes most of care coordinator’s time,
  not coordination with primary care.
- To improve cost and quality of care, focus
  must be on child and family/caregiver(s) —
  takes time.

A System of Care is...
A spectrum of effective, community-based services and supports
for children and youth with or at-risk for mental health or other
Fundamental challenge & rationale for
building SOC:
No one system controls everything.
Every system controls something.

...in order to help families function better at home, in school, in
the community, and throughout life.

The promise of effective community
care can only be attained when we
understand how new practices fit
with the needs and strengths of local
communities and their existing care
systems, and we adapt clinical and
administrative practices to provide
care that changes in response to
community context.

System of care is, first and
foremost, a set of values and
principles that provides an
organizing framework for systems
reform on behalf of children,
youth and families.

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System of Care Core Values

- Family-driven and youth-guided
- Home- and community-based
- Strengths-based and individualized
- Trauma-informed
- Culturally and linguistically competent
- Connected to natural helping networks
- Data-driven, quality and outcomes oriented

Let’s take a closer look at the impact we have seen from implementing a system of care approach....

Enrollment in a SOC resulted in significantly improved clinical outcomes

- Improvement in behavioral & emotional symptoms
- Fewer internalizing and externalizing symptoms
- Improvements in levels of clinical impairment
- Fewer suicidal thoughts & attempts
% of Children & Youth Scoring in Clinically Elevated Range on CBCL (Child Behavior Checklist), Grantees Initially Funded in 2009–2010

After enrollment in a SOC, youth were less likely to be arrested

Percentage of Youth Involved in the Juvenile Justice System for Youth Receiving System of Care Services
Reduced Arrests and Suicide Attempts for Youth Receiving System of Care Services

After enrollment in a SOC, children were
• less likely to visit an emergency room
• Higher rates of educational achievement
• Improved school attendance
• Fewer suspensions & expulsions

Enrollment in a SOC resulted in improved educational outcomes
Improved Educational Outcomes for Children & Youth Receiving System of Care Services

Systems of Care Work & Cost Savings are Realized as a Result of...

- Fewer out-of-home placements/diversion from higher levels of care
- Fewer ER visits
- Fewer arrests
- Greater capacity for caregivers to work
- Youth served in systems of care are less likely to receive psychiatric inpatient services. From the 6 months prior to intake to the 12 month follow up, the average cost per child served for inpatient services decreased by 42%.
- Youth in systems of care are less likely to be arrested, resulting in a 55% reduction in average per-youth arrest-related costs.

COMPREHENSIVE SERVICE ARRAY
## Services & Supports

<table>
<thead>
<tr>
<th>Home- and Community-Based Treatment and Support Services</th>
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<tbody>
<tr>
<td>• Assessment and evaluation</td>
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<tr>
<td>• Individualized, intensive care coordination using Wraparound</td>
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<tr>
<td>• Outpatient therapy – individual, family, group</td>
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<tr>
<td>• Medication management</td>
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<tr>
<td>• Intensive in-home services</td>
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<tr>
<td>• Substance use intensive outpatient services</td>
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<tr>
<td>• Mobile crisis response and stabilization</td>
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<tr>
<td>• Family peer support</td>
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<tr>
<td>• Respite services</td>
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<tr>
<td>• Therapeutic behavioral aide services</td>
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<td>• Therapeutic mentoring</td>
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<tr>
<td>• Behavior management skills training</td>
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<tr>
<td>• Youth and family education</td>
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<tr>
<td>• Mental health consultation</td>
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<tr>
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<tr>
<td>• School-based behavioral health services</td>
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<tr>
<td>• Supported education and employment</td>
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<tr>
<td>• Supported housing</td>
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<tr>
<td>• Transportation</td>
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<th>Out-of-Home Treatment Services</th>
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<tbody>
<tr>
<td>• Therapeutic foster care</td>
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<tr>
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<tr>
<td>• Inpatient hospital services</td>
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<tr>
<td>• Inpatient medical detoxification</td>
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<td>• Crisis respite services</td>
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Specific evidence-informed interventions and culture-specific interventions can be included in each type of service.

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## Federal Medicaid Guidance


## Key Behavioral Health Services & Supports that Should be Available to Every Child & Family

- Strengths-Based, Trauma-Informed Screening, Assessment & Diagnosis
- Psychiatric Consultation to Health Care Providers
- Medication Management & Psychotropic Medication Review Protocols
- Mobile Crisis Response & Stabilization
- Family & Youth Peer Support
- Trauma-Informed Systems
- Evidence-Based & Promising Practices, including Intensive In-Home & Trauma-Informed Services
- Early Psychosis Services in a System of Care Framework
- Respite Care
- Individuated, Intensive Care Coordination using Wraparound
- Flex Funds
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Summary: What Leads to Outcomes?

Program and System Supports → Adherence to a clear theory – and research-based service model → Positive Outcomes!
SYSTEM OF CARE CUSTOMIZATION
APPROACHES FOR SPECIFIC
POPULATIONS

Coordination with Primary Care in a Wraparound Approach

For children with complex behavioral health challenges enrolled in Health Home – Care Management Entity or Wraparound Health Team is responsible for:

- Ensuring child has an identified primary care provider (PCP)
- Tracking of whether child receives EPSDT screens on schedule
- Ensuring child has at least an annual well-child visit
- Communicating with PCP opportunity to participate in child and family team and ensuring PCP has child’s plan of care and is informed of changes
- Ensures PCP has (and provides) information about child’s psychotropic medication and that PCP monitors for metabolic issues such as obesity and diabetes

Emerging Trend: Certified Community Behavioral Health Clinics

- Establishes Prospective Payment System with enhanced Medicaid match
- Criteria for certification includes requirements for:
  - Staffing
  - Availability and accessibility of services
  - Care coordination
  - Scope of services
  - Quality and Other Reporting
  - Organizational Authority, Governance and Accreditation

24 states received planning grants, which will be followed by a 2-year demonstration program for 8 of those 24 states
Trends: Integration at the Practice Level – Medical Home Services for Children

- “All behavioral health conditions except ADHD associated with difficulties accessing specialty care through medical home.”

- “The data suggest that the reason why services received by children and youth with behavioral health conditions are not consistent with the medical home model has more to do with difficulty in accessing specialty care than with accessing quality primary care.”

Suggests a need for more customized, intensive care coordination approaches for children with significant behavioral health challenges.


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Early Childhood Systems of Care

- The service array for early childhood SOCs differs from those SOCs serving older youth and young adults in that it includes promotion and prevention, in addition to treatment services, and most services are infused into natural settings for young children and their families.

- The need for cultural and linguistic competence in services and supports is just as important for early childhood SOCs, as culture plays a major role in child-rearing practices and behavioral expectations.

- The workforce for early childhood SOCs is broad and may include child care providers, teachers, primary care staff, mental health providers, child welfare workers and others. These providers may not be trained in social-emotional development and early identification of mental health problems, which has led to a significant shortage of mental health professionals with the training and skills to effectively serve infants and young children.

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Transition Age Youth (TAY)

- Young adults with mental illness are likely to have a difficult transition to adulthood.

- Addressing behavioral health needs of this age group (18-25) is a critical public health issue because mental health disorders are associated with residential instability, lower educational attainment, unemployment and poorer access to health services.

- As older adolescents begin to transition into young adulthood, it’s important to assess if they have stable housing, are enrolled in school, have insurance coverage or exhibit delinquent behavior.

- Many young people with mental health concerns encounter difficulties once no longer eligible for children’s mental health services. Families may be unaware of changes occurring around age 18 and do not receive adequate education, resources and supports.

- The services from which young adults typically age out include:
  - Eligibility for children’s mental health services;
  - Case management;
  - Supervised, supported, or group home settings;
  - Educational support;
  - Specialized vocational support, preparation, and counseling;
  - Preparation for independent living; and
  - Social skills training.

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (May 6, 2014). The CBHSQ Report: Serious Mental Health Challenges among Older Adolescents and Young Adults. Rockville, MD.
Early Onset Psychosis

Findings in Systems of Care

• Data collected from grantees funded from 2002 to 2010. Participants with EOP at intake (n = 244) included in this sample.

• Youth with EOP do make improvements in systems of care. From intake to 6 months, children and youth show
  – Improvements in behavioral/emotional symptoms & clinical functioning
  – A reduction in suicide ideation and fewer suicide attempts
  – An increase in school attendance

• Children and youth diagnosed as having early onset schizophrenia enter services with more needs. They are more likely to have
  – Higher symptoms levels
  – Previously attempted suicide
  – Troubles attending school regularly


Effective System-Building Process

Leadership & Constituency Building

A Strategic Focus Over Time

Orientation to Sustainability

Structure Organizes Functions

“Something Arranged in a
Definite Pattern of Organization”

Distributes power & responsibility

Shapes and is shaped by values

Affects practice, outcomes and subjective experiences

**Structuring Family and Youth Involvement throughout the System**

**Policy**
- Planning
- System Management
- Benefit Design/Service Array
- Evidence-Based Practice
- Outreach and Referral
- Screening, Assessment, and Linking
- Decision-Making and Oversight
- Delivery Level
  - Care Planning
  - Care Authorization
  - Care Monitoring and Review
- Crisis Management at the Service Delivery and Systems Levels
- Utilization Management
- Family Involvement, Support, and Development at all Levels
- Youth Involvement, Support, and Development at all Levels

**Management**
- Staffing Structure
- Staff Involvement, Support, Development
- Orientation, Training of Key Stakeholders
- External and Internal Communication
- Social Marketing
- Provider Network
- Protecting Privacy
- Reporting Rights
- Billing and Claims Processing
- Quality Improvement
- Evaluation
- System Exit
- Technical Assistance and Consultation
- Cultural and Linguistic Competence

**Services**
- Stafﬁng Structure
- Staff Involvement, Support, Development
- Orientation, Training of Key Stakeholders
- External and Internal Communication
- Social Marketing
- Provider Network
- Protecting Privacy
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- Billing and Claims Processing
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**System of Care Functions Requiring Structure**

- Planning
- System Management
- Benefit Design/Service Array
- Evidence-Based Practice
- Outreach and Referral
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**Tennessee System of Care Timeline**

- Local System of Care Demonstration Grant (1999-2006)
- Children’s Mental Health Policy Academy (2005)
- Senate Joint Resolution 766 (2006)
- Local/Regional System of Care Demonstration Grants (2008-2014)
- Statewide System of Care Expansion Initiative (2012-2016)
- TennCare Child & Youth Mental Health Services Pilot (2010-2015)
- System of Care Across Tennessee Initiative (2017-2020)
Kudos to Tennessee!!!

Tennessee Department of Mental Health and Substance Abuse (TDMHSAS) State Team

Tennessee Commission on Children and Youth (TCCY) – 3 Divisional SOCAT Coordinators

4 Laboratory Sites – Madison, Coffee, Putnam, and Sevier

Local SOCAT Teams

SOCAT Technical Assistance (TA) Center

Kudos to Tennessee!!!

Serve over 600 children through SOCAT Teams and SOCAT Care Coordination Services

Decrease utilization of inpatient care

Reduction of out-of-home placements

Improved community functioning, including improvements in school performance and attendance

Improved and sustained positive mental health, including increases in behavioral and emotional strengths

Sustainability of the SOCAT Teams

GET ALL THE INFORMATION YOU CAN, WE'LL THINK OF A USE FOR IT LATER.
Building Systems of Care = Strategically Managing Complex Change

Vision + Skills + Incentives + Resources + Action Plan + CHANGE
Vision + Skills + Incentives + Resources + Action Plan + CONFUSION
Vision + Skills + Incentives + Resources + Action Plan + ANXIETY
Vision + Skills + Incentives + Resources + Action Plan + RESISTANCE
Vision + Skills + Incentives + Resources + Action Plan + FRUSTRATION
Vision + Skills + Incentives + Resources + Action Plan + TREADMILL

Design for the Future

Progress is the nice word we like to use. But change is its motivator...
The willingness to confront that change will determine how much we shall
really do for our youth and how truly meaningful our efforts will be.
The test will not be how elaborate we make our proposals for new programs
and new funds, but how well these programs affect the inadequacies of old,
how willing we are to change the old.

Attorney General Robert Kennedy
speaking to the U.S. Conference of Mayors, May 25, 1964

Registration is now open!
2017 National Wraparound Implementation Academy
September 11 – 13, 2017
Baltimore, MD Inner Harbor
Click here for registration and details.
The Training Institutes are returning:
July 2018
Washington, DC
Hosted by the University of Maryland School of Social Work

Stay Tuned for More Information Soon!

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