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A support document for the
Call for Change:
Transformation of the
children's behavioral health
system in Pennsylvania
Office of Mental Health and Substance
Abuse Services

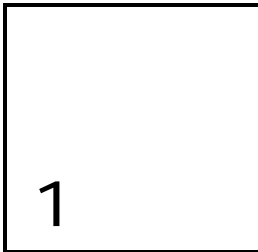
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Introduction

This report provides technical background and review in support of the “Call for Change”, a strategic plan to continue the work of transforming the children’s behavioral health (BH) system into one that is youth-guided and family-driven. The analysis and information in the report documents how this plan builds on past achievements already realized by the Commonwealth of Pennsylvania’s Office of Mental Health and Substance Abuse Services (OMHSAS) in partnership with youth, families, other State agencies, counties, BH managed care organizations (MCOs) and providers. Continuing to work together, we hope to use this document to catalyze future efforts toward even greater access, quality of care and effectiveness for BH services for children and their families throughout the Commonwealth. The following chapters provide a review of the development of children’s BH services in the Commonwealth and an examination of the beginnings of a transformed system that has been put in place. Chapter three describes what components an ideal system might include; chapter four reviews progress to date toward achieving the ideal system and chapter five identifies priority next steps to move further toward that ideal.

The Call for Change grew out of an analysis of the many multi-stakeholder initiatives and children’s services improvements that have been achieved over the past seven years. OMHSAS also sought the direct input of key stakeholders, including youth, families, county mental health (MH) staff, representatives of BH MCOs, Child and Adolescent Service System Program (CASSP) coordinators, provider agencies and advocates. Building on this input, the document also incorporates findings from a review of the current literature on the state of the art in children’s BH services.

OMHSAS vision and guiding principles for youth services

In 2002, advocates for children’s BH services convened a multi-stakeholder work session known as the Search Conference to set a direction for the new administration that would be taking office in 2003. More broadly in their efforts, the Search Conference

report served as a guide for OMHSAS and the Department of Public Welfare (DPW) to develop public sector BH services.

The Search Conference participants identified a number of key issues, including:

- Increased identification and diagnosis of children with various BH disorders, with trends toward more complex and severe BH problems at younger ages and “skyrocketing” rates of autism spectrum diagnoses.
- Increased demand for services and corresponding demand for cost containment, putting “child-serving systems ... in a double bind ... trying to do more with less.”
- Greater need for cross-system collaboration across MH, drug and alcohol, mental retardation, education, juvenile justice and child welfare systems.
- Increasing strain on families’ abilities to negotiate complex Systems of Care related to:
 - Changes in family structure
 - Challenges to natural and community support systems
 - Increased demands upon the discretionary time and financial resources of families
 - A continued tendency for families to be “blamed and shamed” for their children’s BH disorders, complicated by racial and cultural issues, judgmental attitudes and punitive responses of others
- Children with BH disorders being “criminalized” as zero-tolerance policies result in suspensions, expulsions and referrals to the juvenile and criminal justice systems.
- Advances in our understanding of BH disorders, including a better understanding of the relationship between the brain and mental illness, serious emotional disturbance (SED) and behavior.
- An expanding base of knowledge regarding evidence-based interventions able to effectively address BH problems.
- A need to develop more culturally competent services for diverse populations.
- The growing epidemic of substance abuse among young people throughout the Commonwealth.

Many of the system and stakeholder leaders that were involved in the Search Conference continued to provide input and guidance to the developing children’s behavioral health system. Some became members of the OMHSAS Children’s Advisory Committee, which established the vision and principles highlighted below.

OMHSAS vision

Every individual served by the OMHSAS system will have the opportunity for growth, recovery and inclusion in their community, have access to culturally competent services and supports of their choice and enjoy a quality of life that includes family and friends.

Guiding principles

The OMHSAS system will provide quality services and supports that:

- Facilitate recovery for adults and resiliency for children
- Are responsive to individuals' unique strengths and needs throughout their lives
- Focus on prevention and early intervention
- Recognize, respect and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity and sexual orientation
- Ensure individual human rights and eliminate discrimination and stigma
- Are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family
- Are developed, monitored and evaluated in partnership with consumers, families and advocates
- Represent collaboration with other agencies and service systems

Scope and role of the Call for Change

This background report for the Call for Change describes Pennsylvania's consistent history and determined effort toward improving the lives of its youth and families, particularly those who face significant challenges affecting their emotional well being, behavior and functioning in the community. It also lays out potential goals and guidance for further transformation of youth-serving systems toward integrated, effective, accessible and appropriate prevention and intervention options.

In "Reaching for the Stars: A Message for Pennsylvania" (completed between 2004 and 2006), the Children's Behavioral Health Task Force, made up of over 400 stakeholders, found the following:

- Families are not happy. Families want the system to change dramatically.
- Families must be at the heart of the new design.
- Across the board, we must stop our overly simplistic reliance on blaming families for problems, understand the complexities that have brought us to this juncture and believe that we can and must do a better job.
- Providers must rethink what services they provide and wholeheartedly embrace the development of an effective continuum of community services and supports, with residential placement the option of last resort.
- Government must support this change, passing new legislation and reallocating money to make it real.
- Government must create supports and incentives to allow our strong provider network to change and thrive.

- Government must be accountable. Regulations must ensure the ability to measure our efficiency and have the flexibility to stop practices that are not effective or shown to be harmful while at the same time allow for innovation and change as new knowledge is gained.

Since that time, Pennsylvania has made deliberate efforts toward positive change:

- A **Vision** was established in 2007, by the OMHSAS Children's Advisory Committee, which adopted the goal of transforming the system to be family-driven and youth-guided.
- **Services** are improving through increased use of evidence-based practices (EBPs).
- **Settings** for services have expanded with more treatment being done in homes and communities.
- **Systems** are increasingly integrated, with joint initiatives involving the:
 - Office of Policy Development
 - OMHSAS
 - Office of Children, Youth and Families (OCYF)
 - Office of Developmental Programs (ODP)
 - Office of Child Development and Early Learning (OCDEL)
 - Office of Income Maintenance
 - Office of Medical Assistance Programs (OMAP)
 - Pennsylvania Department of Education (PDE)
 - Department of Health (DOH)
 - Bureau of Drug and Alcohol Programs (BDAP)
 - Juvenile Court Judge's Commission (JCJC)
 - Pennsylvania Commission on Crime and Delinquency (PCCD)
- **Youth and family involvement** is becoming a hallmark of service planning, with diverse needs being acknowledged and guiding programs.
- **Success**, as demonstrated through positive outcomes, is more often being achieved.

Many individuals and organizations provided input for the development of this background report. There were many common themes, including the centrality of youth and family involvement, the need for workforce development and the goal of quality, effective services. There were also conflicting perspectives, with some respondents emphasizing the strengths of the system, while others emphasized the problems. One consistent message is that there is a strong, passionate community of stakeholders in the Commonwealth that wants to make sure that the needs of children and families are being addressed. This report tries to capture that spirit and translate it into operational terms to support OMHSAS and the Children's Advisory Committee in their Call for Change.

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Background of children's services in Pennsylvania

Historical perspective

The development of policy and systems devoted to children's emotional and behavioral concerns in order to treat them as health conditions is a relatively recent occurrence, with its origins in the early part of the 20th century. Across time, emotional and behavioral problems experienced by children have been viewed through the prism of the prevailing perspectives of the day, whether religious, moral, or increasingly in the last century, scientific, medical and progressive.¹ Central to this conceptual evolution in the 20th century was the notion that children were to be treated differently because they had different needs and concerns. Some historians have called the 20th century "The Century of the Child".

The child guidance movement of the early-to-mid part of the 20th century shifted the focus in children's MH from punishing children who misbehaved to understanding what forces were influencing the problem and then trying to help correct the behavior (Lourie, 2000). One of the most well known of these guidance centers was in Pennsylvania – the Philadelphia Child Guidance Center directed by Dr. Salvador Minuchin. Following the enactment of the federal Community Mental Health Act in 1963, child guidance centers began to be folded into community MH centers, but services for children were less visible and deinstitutionalization did not really encompass children and adolescents. In fact, several State mental hospitals in Pennsylvania opened units for adolescents, including Allentown, Danville, Harrisburg, Wernersville and Mayview State Hospitals. Eastern State School and Hospital opened in 1965 specifically for children and adolescents. In general, services during this time period for children and adolescents in Pennsylvania

¹ Furman, Rich and Jackson, Robert. (Jul-Sep 2002). Wrap-around services: An analysis of community-based mental health services for children. *Journal of Child and Adolescent Psychiatric Nursing*. Retrieved from http://findarticles.com/p/articles/mi_qa3892/is_200207/ai_n9088511/

were concentrated at the more restrictive end of the continuum.² In 1966, the Mental Health and Mental Retardation Act was passed, which provided the foundation for the development of services throughout Pennsylvania in a partnership through which the State provides most of the funding and county government serves as the local authority, responsible for managing the program.

Clearly, the effort to determine the causes and the best treatment for mental illness was evolving toward a medical orientation. By the mid-1970s, the medical model dominated the field of what became known as mental illness. Over the ensuing two decades, the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association drastically increased the type and number of mental disorders from 112 in the first edition, published in 1952, to 374 in the fourth edition, published in 1994. Many of these newly defined disorders deal specifically with mental illnesses of childhood.³

The 1980s

Significant change in children's MH services, nationally as well as in Pennsylvania, began with the publication by Jane Knitzer in 1982, titled *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*. The publication noted that "of the three million seriously disturbed children in this country, two-thirds are not getting the services they need. Countless others get inappropriate care. These children are 'unclaimed' by the public agencies with responsibility to serve them."⁴ The report further detailed that states emphasized residential treatment and had "almost no capacity to provide nonresidential services" (p. ix) and confirmed what many parents already knew: they were being blamed for their children's problems and had very little access to advocacy, respite, other needed supports or even medical professionals who knew how to communicate effectively with them.

In response to Knitzer's study, Congress created CASSP and funds were appropriated for states to begin to develop comprehensive Systems of Care for children and adolescents with SED and their families. In Pennsylvania, the CASSP children's MH program began to develop in the DPW's Office of Mental Health and the number of staff and responsibilities began to grow in the 1980s. Likewise, with State support, counties began to identify staff with specific responsibility for children's services. A Robert Wood Johnson Foundation grant to the Mental Health Association of Southeastern Pennsylvania (MHASP) helped organize parents of children with SED. The MHASP created Parents Involved Network of Pennsylvania, and this organization began to serve as a support and an advocate for families whose children had MH challenges.

² "A Brief Chronology of Children's Behavioral Health Services in Pennsylvania". (2005). Prepared by the staff of the PA CASSP Training and Technical Assistance Institute.

³ <http://www.faqs.org/childhood/Me-Pa/Mental-Illness.html>

⁴ Knitzer, Jane. (1982). *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, p. ix.

During this period, Pennsylvania applied for and received the first of several federal CASSP grants and began building a State and local infrastructure for a comprehensive System of Care. That infrastructure developed over the next several years into an enhanced emphasis on children and families in the Office of Mental Health, children's MH specialists in each of the State's four regions, CASSP or children's MH coordinators in each county MH program and a statewide CASSP Advisory Committee. The CASSP Advisory Committee was co-chaired by a MH professional and a family member and included representatives from county systems, State child-serving systems, local provider agencies and family members. During this same period, the first children's interagency conference was held in 1987, bringing together, by invitation only, State and county stakeholders from all the child-serving systems in Pennsylvania. In 1990, a separate Division of Children's Services was created in the Office of Mental Health. This division was elevated to bureau status in 1991.

The late 1980s and early 1990s were also a period of substantial service development:

- "Principles of Service for Children and Adolescents in Pennsylvania" was written by an interagency group in the 1980s to guide development of new programs and services.
- "Principles of Cultural Competence" was written by the Minority Initiatives Subcommittee of the State CASSP Advisory Committee in the early 1990s.
- In 1988, Family Based Mental Health Services (FBMHS) was developed "to serve children at risk for out-of-home placement due to psychiatric diagnoses indicating severe emotional or behavioral disturbances and its continuing development has been viewed as a clinically effective, preferred alternative to inpatient hospitalization or psychiatric residential placement" (Lindblad-Goldberg, Jones & Dore, 2004).
- In 1986, the Student Assistance Program (SAP) was implemented primarily to address drug and alcohol issues in the schools, but also included a teen suicide prevention initiative and was later expanded to include a MH component, expanding since then to include SAPs in all 501 school districts in Pennsylvania, serving approximately 80,000 students each year.

The early 1990s

A new opportunity to develop a comprehensive system for addressing the MH needs of children and youth emerged in 1989, when Congress expanded the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provision of Medicaid.⁵ Under the EPSDT provision, states were able to receive matching funds for children's MH services, provided that children met Medicaid eligibility and were diagnosed with a MH condition that impaired their social functioning (medical necessity). In this context, advocates in the Commonwealth were concerned about the level of access to services for children and families and in December 1992, the Commonwealth entered into a settlement agreement

⁵ Furman, Rich and Jackson, Robert. (Jul-Sep 2002). Wrap-around services: An analysis of community-based mental health services for children. *Journal of Child and Adolescent Psychiatric Nursing*. Retrieved from http://findarticles.com/p/articles/mi_qa3892/is_200207/ai_n9088511/

in the Lawrence K. lawsuit to provide expanded access to medically necessary MH services for children who are Medicaid eligible.

Prior to this, the Commonwealth had extended Medicaid eligibility to children and youth that met the definition of disability under the Supplemental Security Income (SSI) classification. In general, if the child has a physical or mental condition(s) that very seriously limits his or her activities, and the condition(s) have lasted or are expected to last at least one year or result in death, an SSI-covered disability may exist and if so, the child is eligible for Medical Assistance (MA), Pennsylvania's Medicaid program) without consideration of parental income. This change is known as Category PH 95 under the MA Eligibility Handbook.

These changes led to dramatic expansion of MH services for children in Pennsylvania. The concept of "wraparound" was presented as an individualized approach to treatment at a national conference in 1989 (Burchard & Clark, 1989), and the combination of this new emphasis and administrative goals within the Bureau of Children's Services put more emphasis and funding at the less restrictive end of the continuum, where the array of service options began to increase dramatically. Major milestones during the first half of the decade included:

- In 1992, a proposal for another CASSP grant was submitted to the federal government to create a statewide training program for professionals who worked with children and adolescents with BH needs. From the beginning the intent was to link the training program with a university, similar to the training institutes that both the child welfare and juvenile justice systems had at the time with Shippensburg University. The CASSP training grant was awarded to Pennsylvania in 1993. It was administered by a Harrisburg-based provider agency, Keystone Service Systems until affiliation with the Pennsylvania State University in 1997. The CASSP Institute has been responsible for training thousands of individuals in the children's BH field in Pennsylvania.
- In 1994, a MA Bulletin was issued that added therapeutic staff support (TSS) services, mobile therapy (MT) and behavioral specialist consultant (BSC) to the MA program fee schedule. Use of these services grew dramatically over the next several years and what had started out being called "wraparound services" became known as behavioral health rehabilitation services (BHRS).
- In 1994, MA funds were made available for MH services provided to children and youth in residential treatment facilities (RTFs), leading to the development of RTFs.
- In 1994, Project ACCESS enabled MA funds to pay for certain services provided in schools. The majority of services were speech therapy, physical therapy and occupational therapy, but some MH services also became available in schools.
- In May 1995, the State CASSP Advisory Committee approved a new discrete set of six core principles for MH services for children and adolescents with SED and their families: Services were to be 1) child-centered, 2) family-focused, 3) community-based, 4) multi-system, 5) culturally-competent and 6) least restrictive/least intrusive.
- In 1996, Eastern State School and Hospital closed.
- In 1997, the last State hospital adolescent unit in Pennsylvania, Mayview State Hospital, closed.

At the same time, significant initiatives were taking place elsewhere that had implications for children's MH services and for cross-systems work in general. These included:

- In 1994, the Annie E. Casey Foundation provided a grant of \$2.5 million to OCYF to fund foster care system reform.
- In 1995, the Community Partnership for Safe Children was established, a youth violence prevention initiative involving PDE, DOH and DPW, along with the State police, the Office of the Budget, PCCD, JCJC and community representatives in identifying successful programs and promoting their replication in other communities. The same year, PCCD launched a risk-focused delinquency/violence prevention program based on the national Communities That Care model.
- By 1997, 48 counties were involved in the planning and implementation phase of Family System Service Reform (FSSR) and worked at integrating FSSR with already existing community structures like CASSP, Communities That Care and Family Centers. The Special Kids Network was established as a statewide referral system, serving families of children with chronic health or disabling conditions.

The late 1990s

The year 1997 was an important one. That year, the Office of Mental Health was renamed OMHSAS, and as part of the reorganization, the Bureau of Children's Services was eliminated and its functions integrated. A focus on BH services began, viewing MH and substance abuse services as a related whole.

A second major and dramatic change also began in 1997, when the HealthChoices managed care program for MA recipients began in five Southeast counties, followed in subsequent years by expansion into the Southwest and Lehigh-Capital regions and eventually (2007) to the entire State in the first half of the next decade. BH services were managed through a contract that was separate from contracts for physical health (PH), and counties were offered the opportunity to submit proposals to manage BH care through arrangements with BH MCOs. The full array of children's services that had been developed by 1997 was included in the BH care plans and the six CASSP principles were cited in the request for proposals as the standard for how managed care services for children and families should be developed and implemented. Another notable requirement of the HealthChoices program was the development of consumer and family satisfaction teams, ensuring family input into the BH managed care program. Through HealthChoices, Pennsylvania established access standards and increased the types of providers eligible to provide care, thus enhancing access and choice.

During the last part of the 1990s and early into the next decade, there were numerous cross-systems initiatives that affected the development of children's services in Pennsylvania:

- In 1997, the Individuals with Disabilities in Education Act (IDEA) was reauthorized by Congress. An interagency work group was created to focus on collaborative efforts in schools; public forums were held and an IDEA Interagency Memorandum of Understanding was eventually issued in 2000 addressing the changes.

- In 2000, the Dependency and Delinquency Health Care Services work group convened as a collaborative effort co-chaired by the deputy secretaries of the OMHSAS, OCYF and OMAP. In 2002, the work concluded with the release of three major products: an access guide to “help front-line workers more effectively navigate the PH and BH care MA-funded systems for youth who are adjudicated dependent or delinquent”, a tool kit to help providers qualify to offer MA services and a directory of services listing all the services available from the various child-serving systems. In addition, funding was given to four counties to participate in the work group’s screening and assessment demonstration project, using the updated Massachusetts Youth Screening Instrument (MAYSI-2) for children and adolescents in juvenile detention centers and shelters to assist in early identification of MH and/or substance use issues.
- In 2001, the Governor’s Community Partnership for Safe Children announced funding availability for research-based programs for violence prevention.
- In 2002, a bulletin was issued on “Performance Expectations and Recommended Guidelines for County CASSP” to guide interagency work for children, youth and families and promote broader adherence to the CASSP principles. Known as the “eight-signature bulletin”, it was signed by officials in OMHSAS, OCYF, OMAP, JCJC, the Office of Mental Retardation (OMR), PDE, the Department Labor and Industry (Office of Vocational Rehabilitation) and Health Promotion and Disease Prevention (BDAP).
- In 2002, the Governor’s Task Force on Early Childhood Care and Education issued a report, *Early Care and Education: The Keystone of Pennsylvania’s Future*. Thirty-four members of the task force represented a wide variety of people, including the secretaries of PDE, DOH and DPW. Its goal was that “all Pennsylvania children should come to school ready to learn and be prepared to succeed, ensuring Pennsylvania’s strong families, a responsible citizenry and an educated and effective workforce.”

The new millennium

Building on the momentum and direction setting of the 2002 Search Conference, and with a new administration in place in 2003, OMHSAS announced the re-establishment of a Bureau of Children’s Behavioral Health Services, with responsibility for oversight of all policy and program development related to children’s BH services. In addition, the new governor issued an executive order forming a Children’s Cabinet and a Commission on Children and Families, re-establishing two more entities that had worked in previous years to coordinate services to children among all the child-serving systems in the Commonwealth.

At the national level, the publication *Achieving the Promise: Transforming Mental Health Care in America*, the final report of the President George W. Bush’s New Freedom Commission on Mental Health, was released in July 2003. Focusing on the fragmentation of MH and broader human service systems, this report signaled a shift toward “transformation” for all MH systems, whether for children or adults. The subcommittee on children’s services called for services based on a System of Care

approach, with a broad array of services and supports to be provided in the child's home, school and community, in partnership with the family and consistent with the culture, values and preferences of the child and the family.

Between then and today, the Commonwealth has launched a broad array of initiatives to work toward this vision. The key initiatives included the following:

Integrated Children's Services Planning (ICSP). In 2003, the new administration launched the ICSP project through DPW. The newly established OMHSAS Children's Bureau took an active role in the development of the DPW bulletin that was issued, requiring county children and youth programs, juvenile justice programs, MH/mental retardation program offices and drug and alcohol single-county authorities to submit an integrated, cross-system children's plan across categorical program divisions.

Integrated Children's Services Initiative (ICSI). In 2004 – 2005, DPW established an initiative to make appropriate use of limited resources for children and their families by identifying BH services and determine which had the potential to be delivered through the MA BH system. More important, this financing change was designed to support the underlying philosophy of integrating children's services. The DPW bulletin identified the following principles for ICSI:

- Creating an integrated system for children to ensure access to a continuum of services.
- Putting the child's needs first in providing timely access to BH treatment services to children in the child welfare and juvenile justice systems.
- Delivering BH services through coordinated planning processes that involve the BH, child welfare and juvenile justice systems.
- Paying for medically necessary BH treatment services through the MA program for eligible children.
- Enhancing the quality and monitoring of the delivery of BH treatment services to ensure successful treatment outcomes.

Policy Academy Team/MacArthur Foundation Model Systems Project ("Models for Change"). In 2004, the Children's Bureau played a lead role in developing a proposal for technical assistance that was submitted to the National Center for Mental Health and Juvenile Justice. This proposal was successful and Pennsylvania was one of eight states selected to participate in a Policy Academy. The Policy Academy work later merged into the MacArthur Foundation Model Systems Project in 2005, when the MacArthur Foundation selected Pennsylvania to be one of the initial states to be part of that initiative.

The Models for Change is an ambitious effort to build a "comprehensive model system" for responding to court-involved youth with BH disorders. Models for Change involved top-level representatives of the State's juvenile justice, MH, child welfare, drug and alcohol and education systems, along with family and youth representatives. One of the hallmark developments was a "Mental Health/Juvenile Justice Joint Policy Statement" formally committing to statewide development of routine screening and assessment of

youth for BH problems, an evidence-based continuum of programs and services for diverting and treating them, opportunities for family involvement in their treatment, appropriate protections for privacy and other legal interests and sustainable funding in support of these practices. Another hallmark was the publication of a Family Monograph that addressed the complex issue of family involvement in conjunction with the justice system.

Act 147. In 2005, the State legislature passed amendments to the law governing consent to treatment, which enabled parents to consent to MH treatment for their children ages 14 – 18. In addition, the legislature ordered the Legislative Budget Finance Committee (LBFC) to evaluate the continuum of MH services for children and their families and to assess the impact and effectiveness of Act 147 with regard to providing MH treatment for children and youth. The report made recommendations for development of a comprehensive plan, expanding the use of EBPs, assisting counties in application of the new consent law and monitoring the impact of the changing developments in services for children with autism spectrum disorder (ASD). Many of the recommendations of the LBFC report eventually were implemented.

Autism Task Force. In response to the dramatic increase in the numbers of children being diagnosed with ASDs, the Autism Task Force was created in 2003. This task force, which was comprised of over 250 family members of people living with autism, service providers, educators, administrators and researchers, was charged with developing a plan for a new system for individuals living with autism and their families that would make Pennsylvania a national model of excellence in autism service delivery. After publishing its final report in 2004, the task force led to the creation of the Office of Autism Affairs, which was transformed into the Bureau of Autism Services in early 2007, within the ODP. The objectives of the Bureau of Autism Services include the establishment of statewide diagnostic, assessment, training and intervention standards and the training of individuals at every level in the system to meet the lifetime needs of Pennsylvanians living with autism.

Considerable systems change has occurred as a result of the autism report and the advocacy and system building of the Bureau of Autism Services. In partnership with the Bureau, OMHSAS has developed guidelines for facilitating service delivery to children and adolescents with ASD and supported infrastructure development, including the training of over 2,000 clinicians to provide functional behavioral assessments, a dramatic increase in the number of children and youth with ASD served through the BH system and implementation of Act 62, legislation, which required coverage for services to children and adolescents with autism by commercial insurance companies.

Youth and Family Training Institute. In 2006, Pennsylvania was selected to be one of the states to receive federally-funded technical assistance as part of the national effort to transform children's MH systems. This technical assistance came from the Georgetown National Training and Technical Assistance Center for Children's Mental Health. Among the outcomes of the transformation technical assistance was identification of the following key transformational goal that was adopted by the OMHSAS Children's

Advisory Committee: ***Transform the children's BH system to a system that is family-driven and youth-guided.***

Wraparound planning was recommended as a planning and support process for youth in families with complex needs, who are likely to need significant support for family engagement and coordination for services received from multiple providers or youth-serving systems. Informed by a national literature review,⁶ OMHSAS determined that it would utilize a model of wraparound based on the principles of the National Wraparound Initiative and chose to implement this as high-fidelity wraparound (HFW). In 2007, OMHSAS made plans to create an institute to focus on training, supporting and monitoring the implementation of HFW and its essential components: engagement with the youth and family, building a collaborative team and use of natural supports. HFW is built on a theory of change that holds that change occurs when people take responsibility and begin to act in a different way. In wraparound, coordination supports help provider agencies move from being providers to being champions of the youth and family. The youth and family move from being consumers of services to being in control of both their services and their lives.

Following a request for proposal process, OMHSAS entered into an intergovernmental agreement with the University of Pittsburgh to establish the Pennsylvania Youth and Family Institute. The Youth and Family Training Institute was established to support the effort to transform Pennsylvania's Children's BH system. The vision of the transformed system is one that will engage and empower child and family teams as the primary determinants of service. The Institute is responsible for extending the practice of HFW across the Commonwealth through the provision and coordination of training and technical assistance to engage and empower youth and their families in the treatment and recovery process. The Youth and Family Training Institute began this effort in 2008, with five counties that were "early implementers" of HFW. That has since expanded to nine counties, with more expansion expected, especially through the System of Care grant which has HFW as a core feature.

Family and youth advocacy. Since the mid 1980s, Pennsylvania has been supportive of the development of family advocacy. The CASSP Advisory Committee served as the formal mechanism, and then in 2006, the OMHSAS Children's Advisory Committee incorporated family involvement in OMHSAS activities, including responsibility for the federal block grant planning. The family movement in Pennsylvania took a major step forward in 2004 with receipt of a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a statewide family network called Pennsylvania Families Incorporated (PFI). PFI works to establish a network among the many family advocacy organizations and family members with children with special needs in Pennsylvania. The new century also marked the development of youth advocacy in the BH field. Youth advocacy has grown remarkably, as evidenced by formal recognition by OMHSAS of a youth advocacy subcommittee that participates in

⁶ Mercer. (2006). Unpublished briefing document.

OMHSAS Advisory Committees. Youth advocacy groups are now evident across the Commonwealth.

Transition-age youth. Consistent with the growth of youth advocacy has been the growing recognition of the unique needs of youth and young adults that are transitioning to adulthood. In 2004, pilot projects were established in five counties to test approaches to enhance community-based supports for individuals with BH challenges, who were transitioning from MH treatment as youth to adulthood, where they would continue to need MH treatment. Several significant steps have been taken since the pilot programs to advance the development of specific services for youth and young adults, including dedicated staffing, enhanced collaboration between various child and adult service systems that impact transition-age youth and young adults and a State Leadership Team Memorandum of Understanding on Transition. Recently, as a result of advocacy by the OMHSAS Advisory Youth Subcommittee, a decision was made to extend peer specialist services to youth, ages 14 – 17. The curriculum is being developed to train staff on how to provide this service.

RTF services. In 2005 and 2006, OMHSAS produced a white paper summarizing best practices for early childhood, child and adolescent services, which highlighted concerns about overreliance on residential treatment.⁷ A subsequent review in 2006 and 2007, of RTF utilization,⁸ led to the formation of the joint OCYF/OMHSAS/DPW Continuum of Care work group, which began meeting that fall to align OCYF and OMHSAS activities and support DPW's goal of reducing use of residential treatment by 50%. While RTFs represent a necessary component of the continuum of care for children and adolescent youth whose behavior cannot be managed effectively in a less restrictive setting, they are among the most restrictive MH services provided to children and youth and, as such, should be reserved for situations when less restrictive placements are ruled out, leading to the 50% reduction goal. Other related efforts include:

- Alternatives to coercive techniques – This committee is working to eliminate the use of unnecessary restraints and ban prone restraints in all child-serving residential programs.
- OMHSAS/OCYF Redirection Project – The project works cooperatively with the Bureau of Juvenile Justice Services within OCYF, county cross-system representatives and OMHSAS field office staff to divert youth with predominant MH issues away from juvenile justice placements and into community-based programs that can meet their needs.
- Sanctuary Project – Pennsylvania entered into partnership with the Andrus Children's Center to bring the nationally acclaimed Sanctuary Trauma Informed Care model to residential services. Twenty-nine providers of residential services have become implementers of the Sanctuary Model, providing a combined total of 2,397 beds.

School-based BH. There has been extensive development of school-based BH services throughout Pennsylvania, including outpatient services, Re-ED (re-education) model

⁷ Mercer. (2006). Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices.

⁸ Mercer (2008). White Paper: Community Alternatives to Psychiatric Residential Treatment Facility Services.

programs, partial hospitalization services and one-to-one support, building on the long-standing SAP initiative. There has also been growing recognition that services alone are insufficient and that it is critical to develop school cultures that are supportive of the social, emotional and behavioral development necessary for academic development. The School Wide Positive Behavioral Supports (SWPBS) initiative is a mechanism for implementing such a culture in schools. In Pennsylvania, SWPBS is being developed in more than 100 school districts. This effort is being led by a State leadership team composed of individuals from PDE, DOH and DPW, along with providers, advocates, family members and BH MCOs. In addition to establishing a supportive and enriched school environment, SWPBS can address the BH needs of students in the school context in partnerships with families and respecting the family's culture, values and preferences.

Early childhood mental health (ECMH). There is a rapidly growing knowledge base on infant and ECMH. Efforts taken in the Commonwealth in the past five years to address this need include:

- ECMH consultation statewide in early learning facilities enrolled in OCDEL's Keystone STARS quality improvement program.
- Specialized training for professionals to earn certification in ECMH.
- Development of an active and energized statewide ECMH Advisory Committee.
- Collaboration among all DPW program offices serving young children, especially OCDEL and OMHSAS.
- Resource development: factsheets, periodic newsletter, Web presence.
- Various other initiatives, including pilot projects for screening in pediatric offices mandated screening using Ages and Stages Questionnaire-Social Emotional in all child welfare facilities and OCDEL.
- Recently, OMHSAS and OCDEL began to implement parent-child interaction therapy through a grant from the Heinz Endowment.

Garret Lee Smith Youth Suicide Prevention grant. In 2008, Pennsylvania became the recipient of a federal grant to address youth suicide prevention. The goal of the Garrett Lee Smith Youth Suicide Prevention Program is to implement an early identification system for youth at high risk for suicide (ages 14 – 24 years) within primary care medical settings in three Pennsylvania counties in order to reduce death by suicide and hospitalization for self injury, as well as to increase identification and access to care for adolescents at high risk for suicide. Over time, the goal is to identify barriers, solutions and resources to support dissemination of this program across the Commonwealth.

Pennsylvania System of Care Project. In October, 2009, Pennsylvania was awarded a federal grant to develop Systems of Care across the Commonwealth to serve youth (ages 8 – 18) and families of youth with serious MH needs. The project focuses on youth who are also involved with child welfare or juvenile justice systems and who are in or at risk of out-of-home placement. The \$9 million grant from the federal SAMHSA covers six years and will be implemented in 15 Pennsylvania counties. A State leadership team comprised equally of youth and family representatives and top officials from MH, child welfare, juvenile justice and the Governor's Commission on Youth and Families, is

responsible for the Pennsylvania System of Care Partnership. The Youth and Family Training Institute supports, monitors and evaluates System of Care development in the counties. Each participating county will utilize the practice model defined by the National Wraparound Initiative to serve at least 50 youth annually, with over 1,000 youth and families to be served during the course of the grant. The ultimate vision is that Pennsylvania will eventually expand this structured, integrated approach to System of Care development to all Pennsylvania counties.

Today

All the work that has been done over the past 20 years on children's BH services in Pennsylvania, across multiple administrations, has led to the present situation. On one hand, as the foregoing chronology demonstrates, much effort has gone into improving the children's system and working collaboratively across systems and there has been much progress. On the other hand, there is still work to be done to streamline the system and break down remaining impediments. In addition, the future will bring new changes through mechanisms such as MH Parity and health care reform. The Call for Change is intended to serve as a guide for the short- and long-term future by identifying specific actions that can build on past accomplishments, incorporate present conditions and accommodate future developments to stay true to the vision of a system that enables children and adolescents, and their families, to achieve their hopes and dreams.

3

An ideal array of behavioral health services for youth and families

The preceding chapter described many efforts and initiatives that together embody principles that, taken as a whole, flow directly from the vision established by the Children's Advisory Committee and shape the contours of an ideal children's BH services system:

- It would have, as its foundation, the promotion of universal practices that support healthy social, emotional and behavioral development.
- All parents, all pediatricians, all school personnel and all children would understand what it takes to support good MH.
- It would include broad availability of all levels of prevention services, widely accessible early intervention services, a readily accessible array of services for children and youth, with situational or moderate challenges, and an integrated System of Care for those youth and families with the most severe difficulties.
- Outcomes would be measured at all levels and there would be incentives for using the most effective programs.
- Partnerships would be developed with other systems, agencies and community supports to successfully offer the various levels of care. Funding sources would be flexible to meet needs. Successful partnerships between systems or agencies would be formalized and replicated.
- Services would be community-based, developmentally appropriate and culturally sensitive.

This direction is in line with the most recent national recommendations. A March 2009 Report Brief for Policy Makers from the National Academies of Science describes a coordinated set of individual, family, primary care-based and school-based prevention services to treat mental, emotional and behavioral disorders, which the report notes "are a major health threat and are as commonplace today among young people as a fractured limb: not inevitable but not at all unusual". The policy brief concludes with the following challenge: "Tools to equip young people who are at risk with the skills and

habits they need to live healthy, happy and productive lives are available. What is lacking are the will, social policies and collaborative strategies to adequately support the healthy development of the nation's young people." The ideal system would address this problem.

For the past several years, OMHSAS has worked in partnership with 1) children, youth and families, 2) its agency partners across the DPW and State government and more broadly, 3) Pennsylvania counties, 4) MCOs and 5) providers to identify the building blocks for a BH System of Care that could better meet these ideals. The collaborative work of these stakeholders has yielded multiple analyses and task force recommendations and, in its supportive role to the work of OMHSAS, Mercer has also helped produce a series of studies over the past five years to identify opportunities for progress.

This chapter describes a vision for what we are calling an "ideal service array." In using that term, we recognize that there is no single approach to developing a System of Care. However, we also recognize that there is an emerging set of empirically-supported BH services that could be available to children, youth and families across the Commonwealth. The articulation of this ideal service array took form through the work of the Services Array Subcommittee of the Continuum of Care work group. In September 2008, that group developed a joint OMHSAS/OCYF Services Array Recommendations report used by the Continuum of Care work group to guide its planning. Concurrently, a detailed review, in 2007 and 2008, identified multiple strategies to use Medicaid funding more strategically to promote the ideal service array, including funding for EBPs and use of joint treatment planning to fund HFW. Over 2009, this work was subsequently used as a basis for analysis of broader service utilization and updated review of the empirical literature on children's services carried out by Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, and presented to State agency and BH MCO leadership in April 2009. The ideal service array presented in this chapter is founded on an acknowledgement that, while the Commonwealth continues to expand BH services, too many resources continue to be spent on treatment models developed in the early 1990s that are no longer the most effective therapeutic option available and that do not maximize the independence and resiliency of youth and families in too many circumstances. The ideal service array offers an alternative, grounded not only in evidence of effectiveness, but also in a fundamental recognition of the strengths of the Commonwealth's children, youth and families.

Prevention

Different programs target different risk factors that could develop into more serious problems at various ages. Partnerships between trusted community agencies (faith-based organizations, schools, recreation centers, etc.) and trained providers can lead to shared cost arrangements or collaborative applications for other funds to cover the costs of offering a particular prevention program to a certain group. The ideal prevention approach would respond to the changing needs of individuals over time

through a seamless system integrating PH and BH, as well as public and private systems.

Among early childhood prevention programs (ages 0 – 5), the earliest effective intervention begins at 20 weeks gestation, with nurses offering weekly, in-home parenting and developmental information to pregnant women or teens at risk; the services continue until the child is two or three years old. Among other positive results, longitudinal study of David Olds' Nurse Home Visiting Program showed 48% less incidence of child maltreatment and 69% fewer convictions through age 15 among visited children (Goodman, 2006).

Parenting programs that broadly educate caregivers about effective parenting and fostering child problem-solving skills have also been successful in helping to empower struggling parents before, or just as, child behavior problems are detected. These include programs such as *The Incredible Years*, *Triple P*, *Raising a Thinking Child* and *Love and Logic*. These lesson-based programs are taught by professionals or paraprofessionals who have the opportunity during the course of the program to notice or screen for more severe difficulties in some families. Appropriate referrals can then be made to appropriate early intervention services and/or community supports can be enhanced. Reimbursement approaches would also need to evolve to support early intervention, since many of the behavioral and family needs that can benefit from these evidence-based programs can be prevented from rising to the level of meeting diagnostic criteria for Axis I and Axis II disorders if intervention is timely.

Prevention efforts shift during latency age (ages 6 – 12) to increase positive social interactions, decrease aggression and bullying and increase academic motivation. School-wide initiatives such as *Positive Behavioral Interventions and Supports* have significantly decreased aggressive incidents among students and increased the comfort and confidence of school staff regarding the school environment. With regard to academic motivation and success, mentoring programs have been successful in increasing children's attendance and achievement, particularly when cultural/ethnic and/or gender matching is possible between children and their mentors.

In the teen years, the focus often shifts to prevention of suicide, substance use, gang/criminal involvement and relational victimization. The availability of mentoring and positive community-based options is a key element in a community's efforts to prevent negative outcomes among adolescents. At this age, more formal screening for difficulties, such as depression or substance use, can reveal the need for more intervention with some youth.

Screening and assessment

A comprehensive and standardized assessment and evaluation process is an essential step for children and youth in need of care. The process would center on timely access to comprehensive assessment for all children that considers each child's and family's strengths and needs and matches those needs to flexible and individualized services

and supports across the entire array of available services. In a recent review of screening and assessment approaches,⁹ Mercer recommended that, while a range of screening and assessment tools are valuable to address specific developmental and specialized BH needs, these tools and the information they make available are only useful to the extent that they are employed within an organized framework featuring cross-system communication across the MH, child welfare and juvenile justice systems in particular. A three-level model for organizing assessment approaches was offered that included:

- **Initial screening** – These are brief screens conducted in non-MH settings (e.g., primary care, child care, child welfare, juvenile justice settings) that emphasize quick, efficient and reliable screening. Examples include the MAYSI-2, Ages and Stages and other tools.
- **Comprehensive assessment** – Children and youth demonstrating likely need for BH services based on the initial screen would be referred to a BH provider who would complete a comprehensive assessment of their service needs. The framework for a comprehensive assessment process would standardize the communication of assessment findings.
- **Specialized evaluation** – As needed, children and youth would receive specialized assessment in areas requiring additional specialized intervention, including ASDs, trauma and substance use.

In addition, much of the most recent work in this area centers on BH screening, brief intervention, referral and treatment supports in primary care settings. The construct of pediatric medical homes has emerged as a key means of integrating BH supports in pediatric primary care settings. Key principles of that construct for children and families include:

- **Improved care coordination** across providers, settings and service recipients and their families.
- **Health information technologies** (notably registries, electronic health records and decision support tools) to supported BH service delivery in primary care settings.
- **System reorganization and integration** to make behavioral specialists available in primary care settings.
- **Supports to “activate” parents and youth as partners** in their own care and direct participants in quality improvement activities.

Another important component of an ideal service system would be the availability of family and youth partners and related family supports, at the time of the initial system contact, to provide resources and orientation to the BH system and to help families navigate and be informed about the full range of options available across the BH service array. Key features of the assessment process itself would include:

- Hearing and valuing, in a culturally affirming way, each youth's and family's perspective regarding the problem(s), goal(s) and potential solution(s).

⁹ Mercer. (2008). Unpublished briefing paper.

- Offering options for extended assessments in homes and in schools for all children in need of more in-depth evaluation.
- Incorporating additional screening and standardized assessment tools as appropriate, based on developmental level and presenting issues.

A broad range of evidence-based, community-based interventions

There is growing evidence that, in most situations, children can be effectively served in their homes and communities and that community-based treatment programs are often superior to institution-based programs. Studies show that, with the exception of youth with highly complex needs or dangerous behaviors, such as fire setting or repeated sexual offenses, programs in community settings are more effective than those in institutional settings, with intensive, community-based and family-centered interventions the most promising. Even children and adolescents with SEDs and longstanding difficulties can make and sustain larger gains in functioning when treatment is provided in a family-focused and youth-centered manner within their communities.

The development and dissemination of evidence-based psychosocial interventions for children and adolescents has rapidly developed in recent years. The ideal system would have the following treatment protocols offered in clinics, schools or homes with the objective of: 1) decreasing problematic symptoms and behaviors, 2) increasing youth's and parents' skills and coping and/or 3) preventing out-of-home placement. Core components of some of these interventions should also be used as part of an individualized treatment plan for a child of any age who is receiving intensive intervention in a day treatment program. The following examples of evidence-based and other best practice treatments are offered as examples of the types of services needed in the ideal system and are not intended to be an exhaustive inventory of potential community- and EBPs.

During the preschool years, parent/caregiver participation in treatment is an essential part of success. An ideal service array should include interventions, such as the following:

- *Preschool Post-Traumatic Stress Disorder Treatment, an approach* adapted from trauma-focused cognitive behavioral therapy (TF-CBT) and trauma-focused coping to help young children recover from traumatic events with support from their parents throughout the treatment process.
- *Parent-Child Interaction Therapy (PCIT)*, which is offered for up to 16 sessions in outpatient clinics or in homes; PCIT has a significant evidence base as a protocol for decreasing oppositional behavior in young children, as well as an emerging evidence base as an intervention that increases positive parenting and decreases re-involvement with child welfare.
- *ECMH Consultation* offered in daycare settings in order to collaborate with teachers and parents in identifying difficulties and decreasing significant problem behaviors.

- *Child-Parent Psychotherapy (CPP)*, a trauma-focused treatment offered in-home, for approximately one year, to young children and non-offending caregivers who have experienced domestic violence.

For latency-aged children, individual cognitive behavioral techniques are effective, parent work is still important and some group therapy can begin. Examples include:

- *CBT*, offered in outpatient or school-based clinics, sometimes concurrently with medication(s), to address depression and/or anxiety.
- *TF-CBT*, offered for 12 – 16 sessions in outpatient or school-based clinics for traumatic stress and traumatic grief.
- *Behavior therapy, medication management and parent education*, offered in outpatient or school-based clinics to decrease symptoms of attention-deficit/hyperactivity disorder.
- *Abuse-focused CBT*, offered in outpatient clinics for child physical abuse and problematic parenting.
- *Aggression Replacement Therapy*, offered in outpatient clinics or day treatment settings for children exhibiting significant aggression.
- *Attachment-based Family Therapy*, offered in outpatient clinics to improve child behavior and family relationships.
- *Brief Strategic Family Therapy*, offered in outpatient clinics to improve child behavior and family relationships.
- *Cognitive Behavioral Intervention for Trauma in Schools* group therapy, offered in school-based clinics to address symptoms related to a common traumatic event.

For adolescents, the same EBPs as above should be available in outpatient and school-based clinics, as should the programs, such as the following for teens with severe difficulties, including those that may be at risk for out-of-home placement:

- *Dialectical Behavior Therapy (DBT)*, a group therapy approach offered in outpatient clinics to adolescents with borderline personality features.
- *Functional Family Therapy (FFT)*, offered in outpatient clinics or at home to youth with minor juvenile justice involvement and/or substance abuse.
- *Multisystemic Therapy (MST)*, an intensive service offered several times per week in the home, school and community, for two to five months, for teens with juvenile justice involvement.
- *MST-Psychiatric (MST-P)*, an approach similar to MST, but adapted for teens with serious emotional disorders.
- *HFW*, an integrated care coordination approach delivered by professionals, alongside youth and family partners, for children involved with multiple systems and at the highest risk for out-of-home placement.
- *Assertive Community Treatment for Transition-Age Youth*, using a recovery/resilience orientation, which offers community-based intensive case management and skills-building in various life domains, as well medication management and substance abuse services for youth ages 18 – 21, with severe and persistent mental illness.

Out-of-home intervention options

Treatment of youth in residential facilities is no longer thought to be the most beneficial way to treat those with significant difficulties. The 1999 Surgeon Generals' Report on Mental Health states: "Residential treatment centers (RTC) are the second most restrictive form of care (next to inpatient hospitalization) for children with severe mental disorders. In the past, admission to an RTC was justified on the basis of community protection, child protection and benefits of residential treatment. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings, according to limited evidence."

Residential treatment represents a necessary component of the continuum of care for children and adolescent youth whose behavior is not managed effectively in a less restrictive setting. However, residential treatment is among the most restrictive MH services provided to children and youth and, as such, should be reserved for situations when less restrictive placements are ruled out. For example, specialized residential treatment services are supported for youth with highly complex needs or dangerous behaviors, such as fire setting, that may not respond to intensive, nonresidential service approaches (Stroul, 2007). Yet, on a national basis children and youth are too often placed in residential treatment because more appropriate community-based services are not available.

Nevertheless, youth do sometimes need to be placed outside of their homes for their own safety and/or the safety of others. Safety should be the primary determinant in selecting out-of-home treatment as an option, as the evidence-based community interventions described above allow for even the most intensive treatment services to be delivered in community settings. Whether the situation is temporary, due to a crisis or for longer term care, the ideal service system should include an array of safe places for children and youth.

A family-driven, youth-guided, community-based plan should follow the child or youth across all levels of care (including out-of-home placements, as applicable) and help him/her return to home as quickly as possible, knitting together an individualized mix from among the following array of services.

A full continuum of crisis response, with mobile supports and short- to intermediate-term, local out-of-home options, including respite, psychosocial and BH interventions for youth and their families jointly supervised by counties, BH MCOs, OCYF and OMHSAS should include:

- A mobile crisis team for children and families, with the capacity to provide limited ongoing in-home supports, case management and direct access to out-of-home crisis supports, modeled on Wraparound Milwaukee's Mobile Urgent Treatment Team (MUTT).
- A bio-psychosocial assessment, supported by protocols to communicate assessment results across professionals and to determine the appropriate level of services.

- An array of crisis supports tailored to the needs and resources of the local System of Care, including an array of options such as:
 - Crisis foster care (a few days up to 30 days)
 - Crisis group home (up to 14 days)
 - Crisis respite (up to three days)
 - Crisis runaway shelter (15 days)
 - Crisis stabilization (30 – 90 days) with capacity for 1:1 MH crisis intervention
 - Crisis supervision (30 – 90 days) to maintain safety in the community
 - Placement stabilization center, providing out-of-home respite
 - Acute inpatient care
 - Consultation
 - Linkages to a full continuum of empirically supported practices

A residential continuum of placement types, grounded in continued connections and accountability to the home community, should focus on the following specialized programming:

- *Multidimensional Treatment Foster Care*: a short-term, out-of-home placement with intensive treatment services and monitoring, to prevent longer-term institutional residential treatment and transition the youth back home successfully.
- Gender-responsive services that go beyond just a willingness to serve female youth and that includes a continuum of out-of-home treatment options for young women with BH needs (including histories of sexual maltreatment) and specialized residential programming for youth with gender-identity issues.
- Secure RTF for those youth whose behaviors require treatment in locked, secure settings for the safety of the youth and others. Success of this level of care will likely require:
 - Availability of the full continuum of residential and community-based treatment to youth adjudicated as delinquent, so that these youth are not disproportionately or otherwise inappropriately served in secure RTF settings.
 - Development of multiple types of secure RTF settings, so that youth requiring secure RTF to protect others (particularly from violent or sexual assault) or youth requiring secure RTF to protect themselves (particularly from debilitating conditions, such as developmental disabilities or self-harming behaviors) are not inappropriately mixed within a single unit due to a lack of capacity.
 - Protections to ensure that secure RTF is not overused as a treatment setting for youth at risk of running away.
 - Careful consideration of the potential risks and benefits of expanding this service type to serve more than just youth adjudicated as delinquent.
- Other specialized RTF programs, including treatment for co-occurring MH and developmental disabilities (ASD, mental retardation) and co-occurring MH and substance use disorders.
- Residential placement options that vary by intensity of service provided, primary clinical needs addressed and targeted length of stay such as:
 - Extended sub-acute stabilization and evaluation: Acute-oriented RTFs to serve as an inpatient alternative, in which children and youth could be stabilized, complex

- needs evaluated and treatment begun while transition planning back to a more natural environment takes place.
- Medium-term, family-oriented RTF: A specialized RTF model (referred to by informants as “family-based RTF”) that would meet the needs of youth and community safety while simultaneously working with families intensively and providing empirically supported treatment on an intensive level (e.g., sanctuary model, other trauma-informed approaches and the incorporation of treatments, such as DBT). In such a model, a child or youth might have a brief placement (30 to 60 days) in a facility with fewer beds and then return to the community, with intensive services in place.
 - Longer-term (three to 12 months) intensive and restrictive RTF: Long-term restrictive options will continue to be necessary for a subset of youth with ongoing complex or dangerous behaviors. As these services continue to be needed, it will be important to continue to encourage intensive treatment services, as well as the minimization of restrictiveness, by pursuing placement as close to home as practical and involvement in the community by the child or youth, as clinically appropriate. This level of care will also require intensive work with the family to ensure that skills are transferred to key adults in the home and community and that any significant issues identified in the home as needing to be addressed are incorporated into the youth’s overall treatment plan.
 - Small group homes closer to the community: Less intensive, less restrictive, smaller residential facilities can serve as a transition or step-down for youth returning to the community from long-term restrictive placement when this is needed. Such small group homes can also serve as a brief placement that allows a higher level of community involvement than traditional RTF.

When residential treatment is provided, there should be extensive involvement of the family. Residential (and community-based) services and supports must be thoroughly integrated and coordinated and residential treatment and support interventions must work to maintain, restore, repair or establish youths’ relationships with family and community.

Family involvement is essential throughout the course of residential treatment, and especially at admission, in the development of the treatment plan when milestones are reached and in discharge planning.

Behavioral health disparities and cultural competence

The well-documented and long-standing disparities in health care service availability, quality and outcomes for racial and ethnic minorities negatively affect individuals, families, communities, effective delivery of EBPs and overall health care costs. This is as true for BH as for health care more broadly. Cultural and linguistic competence has emerged as a fundamental requirement to eliminating racial and ethnic disparities in health care services and outcomes. Therefore, an ideal array of MH services for children, youth and families must adequately address cultural issues in treatment. The President's New Freedom Commission on Mental Health recognized that achieving the goal of

eliminating disparities in MH services requires improving access to quality care that is culturally competent (US Department of Health and Human Services (DHHS), 2003). The 2001 report, *Mental Health: Culture, Race and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General*, defines culturally competent services as “the delivery of services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs and values” (Surgeon General, 2001).

The National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS standards)¹⁰ were adopted in 2001 by the US DHHS Office of Minority Health. The goals of the CLAS standards were “equitable and effective treatment in a culturally and linguistically appropriate manner ... as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers” in order “to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.” They include 14 standards, addressing the broad themes of culturally competent care, language access and organizational supports for cultural competence. A range of standards for specific populations is also available,¹¹ but the CLAS standards are most widely recognized in the broader health field. In MH, a set of standards for African American, Asian American/Pacific Islander, Hispanic/Latino and Native American/American Indian groups is also available.¹²

These standards set the current benchmark against which the performance of health care organizations that receive federal funds are assessed and are intended for wider use by a range of stakeholders, including individual providers, accrediting and credentialing agencies, policy makers, purchasers and advocates. The CLAS definition of cultural and linguistic competence is based on the 1989 work of Cross, Bazron, Dennis and Isaacs and is specified as follows:

Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities (pp. 4-5).

¹⁰ US Department of Health and Human Services (USDHHS), Office of Minority Health. (March 2001). National Standards for Cultural and Linguistically Appropriate Services in Health Care. Washington, DC.

¹¹ The New York City Department of Health and Mental Hygiene has compiled a helpful listing of various sources that are readily accessible: <http://www.nyc.gov/html/doh/downloads/pdf/qi/qi-ccpriority-resources.pdf>.

¹² USDHHS, SAMHSA. (2001). Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented □ Racial/Ethnic Groups. Rockville, MD.

The National Standards on CLAS delineate 14 standards for health care institutions to address, as follows:

- Guidelines addressing culturally competent care which state that health care organizations should:
 1. Ensure that persons served receive, from all staff members, effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
 2. Implement strategies to recruit, retain and promote, at all levels of the organization, a diverse staff and leadership that are representative of the demographic characteristics of the service area.
 3. Ensure that staff at all levels, and across all disciplines, receive ongoing education and training in culturally and linguistically appropriate service delivery.

- Mandates for all recipients of federal funds, which address language access services and state that health care organizations must:
 4. Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each person served with limited English proficiency, at all points of contact, in a timely manner during all hours of operation.
 5. Provide to persons served in their preferred language both verbal offers and written notices, informing them of their right to receive language assistance services.
 6. Assure the competence of language assistance provided to limited English proficient persons served by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the person served).
 7. Make available easily understood consumer-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

- Guidelines addressing organizational support for cultural competence, which state that health care organizations should:
 8. Develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
 9. Conduct initial and ongoing organizational self-assessments of CLAS-related measures into their internal audits, performance improvement programs, consumer satisfaction assessments and outcome-based evaluations.
 10. Ensure that data on the individual person's race, ethnicity and spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.
 11. Maintain a current demographic, cultural and epidemiological profile of the community, as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and consumer involvement in designing and implementing CLAS-related activities.
 13. Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by persons served.
- A final recommendation regarding organizational support for cultural competence, which states that health care organizations:
 14. Are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

In 2004, the National Technical Assistance Center for State Mental Health Planning (NTAC) and the National Association of State Mental Health Program Directors (NASMHPD) issued a report describing best practice strategies for promoting cultural competency.¹³ The guidelines in this report focus on the importance of ongoing data collection and related quality improvement activities in the promotion of cultural competence. The report describes steps to institutionalize a comprehensive infrastructure at the State level in support of improved cultural competence and reduced health disparities over time, centering on leadership, self-assessment, performance standards, measurement of performance related to those standards and quality improvement practices to improve performance.

Building on the CLAS consensus-based standards, various researchers and advocates (such as the National Child Traumatic Stress Network (NCTSN)) have recognized an expanded list of populations whose histories, traditions and coping strategies have been passed down (through generations or cohorts) and are relevant to their cultural identity and emotional well-being (NCTSN, 2005). These culturally rich communities may cross traditionally recognized racial and ethnic minority group boundaries. They include, but are not limited to, members of the following communities:

- Deaf and hard-of-hearing, and children of deaf adults (CODAs)
- Lesbian, gay, bisexual, transgendered, questioning, intersex or two-spirit (LGBTQI2-S)
- Specific religious groups, such as Jewish, Muslim, Evangelical, Hindu, etc.
- Refugees and their children
- Immigrants and their children
- Rural American families
- Military personnel and their families
- Emergency/rescue personnel, such as police or firefighters

¹³ NTAC and NASMHPD. (September 2004). Cultural competency: Measurement as a strategy for moving knowledge into practice in state mental health systems. Alexandria, VA: NASMHPD. Retrieved from http://www.nasmhpd.org/general_files/publications/cult%20comp.pdf.

Establishment and maintenance of a culturally competent MH system for youth and families should include the following non-exhaustive list of tasks:

- Incentivizing cost-effective, evidence-based, culturally-adapted practices
- Developing culturally-specific outreach and service delivery models
- Conducting culturally-specific focus groups with consumers and families
- Developing, implementing and monitoring strategies for culturally-affirming services
- Developing MCO- and provider-level training plans for implementation and continuing education in the areas of culturally and linguistically competent services
- Maintaining adherence to CLAS standards
- Implementing an effective model for the use of culture brokers in providing services to certain groups

The needs of unique populations

Fetal Alcohol Spectrum Disorders (FASDs). Recent figures estimate that each year one in 40,000 children in the nation are born affected by FASD. Of these children, up to 750 will be born with fetal alcohol syndrome, the more severe form of this disorder. The estimated cost of treating these children is upwards of \$6 billion dollars annually (SAMHSA, National Organization of Fetal Alcohol Syndrome website). The effects of early exposure to alcohol can produce hidden neurological impairments, which may be the underlying cause for a range of behavioral and cognitive deficits. Children with neurological damage do not respond to many behavioral modification techniques because the child is unable to comprehend cause and affect relationships. Education and awareness of these neurobiological differences are imperative if treatment is to be effective. FASD may too often still be an invisible global disorder, but with early intervention and supports, the secondary symptoms can be avoided or reduced in severity.

Traumatic brain injury. In 2006, a DPW work group identified a range of recommendations specific to children with brain injury. These included:

- Children with brain injury who access public funding will be identified and connected to cognitive and behavioral rehabilitation through a system of:
 - Standardized screening across the Medicaid, Early Intervention, MH, OMR, special education, juvenile justice, children and youth and the Bureau of Drugs & Alcohol in DOH systems.
 - Neuropsychological evaluations and brain injury rehabilitation provided under Medicaid EPSDT reimbursement.
- Brain injury services will be evaluated and coordinated between service systems such as Early Intervention, OMR, MH, juvenile justice, children and youth, the Bureau of Drugs & Alcohol in DOH and the education system.
- A transition process will be implemented from child serving systems into adult serving systems to ensure consistent and comprehensive services for individuals with brain injury.
- A standard, comprehensive, best practices module for brain injury rehabilitation will be incorporated into every child-serving system, supported by ongoing staff training and annual refinement of the module.

Children who are deaf or hard of hearing. Childhood deafness is a low incidence condition, but while the incidence is low, the needs can be high and the numbers of trained professionals available to provide care is much lower. Many children who are deaf are born to parents that can hear and communication difficulties often are present throughout the developmental period. For children who are not deaf, but have some hearing loss, there can also be significant social and emotional challenges. Although, they can act and sound like children without hearing loss, their hearing loss and its global impact on the child and family's well-being is frequently overlooked. In addition, the degree to which the child and family identify with deaf culture is an important variable when considering the degree to which the child and family experience hearing loss as an impairment and experiences of this can differ between family members.

There are still limited specialty services for children who are deaf or hard of hearing in the Commonwealth. The most effective services appear to be school-based, in which MH professionals provide on-going counseling, therapy and advocacy in the school environment. A continuum of services would be provided by staff who are fully sign-language proficient and who understand deaf culture. Needed services include outpatient, case management, family therapy and BHRS. Residential treatment may also at times be needed, as well as less restrictive alternatives, such as therapeutic foster care, using well-trained host families.

Children with ASD. The service system for children with ASDs is still evolving. In Pennsylvania, the Bureau of Autism Services has provided training in Functional Behavioral Assessment (FBA) to over 4,000 staff across the Commonwealth. FBA is to serve as the basis for developing individualized plans for children with ASD and their families. In the ideal system, a full array of evidence-based services grounded by such comprehensive assessments would be available for children and their families.

Youth with substance use disorders (SUDs). Families and caregivers are an integral part of the treatment process for youth and their inclusion increases the likelihood of successful treatment. Services should begin with a full bio-psychosocial clinical assessment that identifies SUDs, co-occurring MH disorders and associated family support and functioning. An example of one such widely used clinical assessment instrument is the Global Appraisal of Individual Needs. This instrument is in the public domain and cross-walks to DSM-IV-TR and ICD-10 diagnostic criteria, as well as the American Society of Addiction Medicine Patient Placement Criteria II.

EBPs such as the Assertive Community Reinforcement Approach, Assertive Continuing Care and Multi-dimensional Family Therapy are among practices that have proven effective for community-based, family-centered treatment of SUD. Some such approaches are also in the public domain, allow for cost-effective training of multiple staff and are amenable to a train-the-trainers approach, ensuring sustainability over time.

Children and families in rural areas. There are vast sections of Pennsylvania that can best be described as rural areas. There are special considerations, including work force development, recruitment and retention issues, cost factors related to travel and other

factors, recognition and valuing of rural culture, and the potential for technological solutions such as telemedicine. Rural counties have recommended a focus on involving them in the development of the ideal BH array of services and in addressing the challenges of adapting and providing that array in rural areas of the Commonwealth.

Implementing evidence-based and promising practices

Both the national literature and Pennsylvania public BH system stakeholders have moved toward consensus that an optimal family-focused and youth-guided service array will include the specified EBPs and emerging research-informed BH services described above for youth and families at highest risk due to behavior or complex multi-system involvement. When implemented with sufficient supports and monitoring to achieve fidelity to the defined models, these practices offer proven means for accomplishing priority outcomes for Pennsylvania's children, youth and families in need of BH services.

Efforts to promote a wide range of evidence-based and research-informed practices have begun to be subjected to systematic study in the past decade and Fixsen and his colleagues summarized the lessons learned through that research in their seminal 2005 work.¹⁴ Their detailed review describes a multi-year, six-stage process, involving: 1) exploration and adoption, 2) program installation, 3) initial implementation, 4) full operation, 5) innovation and 6) sustainability. The process of moving from one stage to the next involves a complex interplay of organizational capacities, technical expertise and quality improvement over time. Fixsen and his colleagues describe three levels of influence that together determine successful implementation: 1) core implementation components, including specific training, coaching and performance measurement related to the practice being implemented, 2) organizational components, including staff selection practices, program evaluation capacity, administrative capacity and ability to carry out systems interventions and 3) external influence factors at the social, economic and political level. Pennsylvania's commitment to weave together the complex technical, organizational and broader system factors influencing best practice implementation is as critical as the identification of and commitment to implementing specific best practices. True system transformation is multi-determined and dependent on sustained organizational commitment and broader organizational capacity development over time.

A fully functioning continuum of services will also allow for innovation in developing service approaches. If these approaches are defined and based on the key elements of established EBPs, there is much reason to expect that they also will bring about successful outcomes. Fixsen and colleagues draw a distinction between evidence-based **programs** with a strong research base and the elements of evidence-based **practices** that can be combined within a range of programs. The latter can be combined to develop promising practices: innovative approaches that are based on the researched elements

¹⁴ Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida. Retrieved from http://www.fpg.unc.edu/~nirn/resources/publications/Monograph/pdf/Monograph_full.pdf.

of success from other more established EBPs (Fixsen et al., 2005). These elements include:

- Concentrating on changing behavior and improving pro-social skills
- Focusing on problem solving with both youth and their families
- Employing multiple modes of intervention
- Goal-oriented treatment
- Promoting healthy bonds with pro-social members within the child or youth's family, peer, school and community network
- Attention to transitions and links to community
- Attention to traumatic events, traumatic stress symptoms and trauma-informed treatment components
- Training and quality assurance to support quality clinical work

If these elements are present, it should be possible to develop locally-tailored programs to an extent sufficient to allow for the design of fidelity tracking protocols and outcomes measurement. Thus, the more traditional or existing practices that have been developed in provider communities may join the evidence-based culture, if a true culture of evidence-based care is developed around them. Without implementing a broad array of supports to promote initial adoption of and ongoing adherence to evidence-based protocols, efforts to promote improved care and achieve improved outcomes through EBPs appear much less likely to meet with success.

Implementation and maintenance of the ideal service array and use of EBPs should be supported by four parallel mechanisms, discussed below.

The first is **training**. Having an adequately trained workforce is essential for proper implementation of effective services and EBPs. Experienced staff must be newly trained and new professionals and peer support staff that will do the work in the future will need to be trained in the specific practices they will provide. Top priorities identified in this area should center on a comprehensive and coordinated system of training and certification with proficiency testing on key concepts and performance requirements that vary according to each provider's role within the system. Key features of these systematic training requirements would include basic training and proficiency requirements for all child-, youth- and family-serving staff to be completed prior to, or shortly after, the time of hire that include a standardized training curriculum, with certification focused on the elements of care common to evidence-based and best practices for children, youth and families. This would be augmented by ongoing training and supervision tailored to the specific services being provided, to include didactic formats, as well as clinical review or observation. Training should include significant focus on special populations with co-training and participation in curriculum development by members of those groups whenever feasible. Resources should also be committed to effectiveness research and standardization of training curriculums and development of fidelity tools for emerging promising practices that lack them.

The second is a **standardized outcome assessment system** for all child and family services to document the effectiveness of the workforce and the services provided. Key components of this outcome monitoring system would include:

- Use of a standardized outcome tool that is both easy to administer in practice-based settings, but also sensitive to change for the populations and settings in which it is used. To the extent a single tool can be used statewide, comparison across settings, populations and types of services is made easier.
- Data collection methodologies that allow for both immediate, case-specific feedback to providers to assess treatment progress and inform treatment planning.
- Data collection methodologies that allow for system level feedback on the effectiveness of specific programs and/or provider practice patterns.
- Measurement of other outcomes relevant to particular EBPs, such as rates of re-hospitalization for ACT or delinquency for MST.
- Inclusion of parents, caregivers, families, youth and providers in the development and implementation of a comprehensive outcomes system.

The third is the implementation of **fidelity monitoring** systems that:

- Have been developed specifically for the specific practices being implemented.
- Provide feedback at the practice level to improve quality of implementation over time.
- Provide feedback at the system level to monitor implementation and inform system-level planning to improve adherence and quality.
- Can be combined with outcome assessment and expenditure data to assess the cost-effectiveness of services over time.

The fourth is the development of **payment approaches** that:

- Incorporate structures to a) incentivize quality, b) support quality training and supervision and c) cover the costs of fidelity monitoring for EBPs and outcomes assessment by providers.
- Move the reimbursement system away from a fee-for-service focus to one which rewards improved outcomes based on statewide and specific measures.
- Adequately reimburse for the additional costs necessary to maintain and expand the flexibility of community-based services that require a mobile component.

A partnership with youth and families

The most critical element in the ideal service array remains the partnerships with the youth and families who are to be served. Services need to be implemented with a strong focus on youth and family engagement, including a commitment at the system and agency levels to continuous quality improvement in partnership with youth and families.

Key components of this commitment include:

- Active family/youth advisory groups
- Support of dialogue to reduce youth and family apprehension about expressing concerns
- Demonstrating clear evidence of youth and family empowerment
- Psycho-education for youth and families
- Incorporation of youth and family advocate positions

- Requirements that providers must offer youth and family support groups
- Requirements that providers must fully understand available community resources and demonstrate appropriate use of the full range of available services
- Provider profiling that informs youth and families and empowers them to make informed choices (this should include information on both quantifiable quality indicators and data from youth-informed and family-driven evaluation)

Taken together, the ideals set for the Commonwealth set a high bar, one that may not be achievable in the short term. However, the needs and resilience of Pennsylvania's children, youth and families demand high standards and some progress toward realizing these high standards has been made, as described in the next chapter.

4

Progress so far in developing behavioral health services for youth and families in Pennsylvania

A strong beginning

The last chapter described an ideal service array based on the work of OMHSAS and its wide range of partners: families, youth, State government partners, county agencies, MCOs and providers. Taken together, this paints a comprehensive picture of a better system for supporting the resiliency and serving the BH needs of children, youth and families in Pennsylvania. This chapter summarizes Pennsylvania's progress through early 2010 in developing such BH Systems of Care.

Numerous efforts by OMHSAS and its partners have resulted in substantive steps forward in providing the ideal service array. In addition to the guidance from the many reports and analyses described in the previous chapters of this report, a range of specific initiatives has been undertaken to facilitate the funding and implementation of effective programs for youth throughout the State. These include:

- The interagency planning efforts of Pennsylvania's BH (OMHSAS) and child welfare/juvenile justice (OCYF) agencies to reform and improve the juvenile justice system, including the Commonwealth's involvement in the MacArthur Foundation's Models of Change initiative through the PCCD. This project has focused on reforms within the juvenile justice system and the dissemination of evidence-based treatment models that will reduce criminal recidivism in teens. The establishment of the vision has prompted counties to determine how to improve their systems for serving youth in the juvenile justice systems. The expanded use of screening and assessment has led to earlier identification of youth with BH problems and thereby diversion from the juvenile justice system.
- The work of OCYF, through the National Governor's Association Policy Academy's foster care initiative, that has focused on reforms in the foster care system and the promotion of research-based practices to find familiar homes and facilitate







- permanency planning for youth in State custody. In the first year, there has been a 20% decline in out-of-home placements in the participating counties.
- OCYF's efforts to broaden access to EBPs for youth with BH needs in the child welfare and juvenile justice systems and their families. Beginning in 2007, and continuing through 2009, OCYF set aside funding for special county grants to support and implement EBPs.
 - OMHSAS and OCYF have worked together within the broader DPW, through partnerships with individual county child-, youth- and family-serving agencies, to implement the ICSP process, which provides the framework for ongoing county planning across BH, child welfare, juvenile justice, education and community partners to coordinate their child and family services across agencies and funding streams. Nearly all counties have received funding and are establishing structures and strategies through this effort that are improving the integration of children's services.
 - OMHSAS' participation in the Trauma Informed Care Cross-Systems Collaboration, under the leadership of Disability Rights Network of Pennsylvania (DRN) and the Pennsylvania Coalition Against Rape (PCAR) has catalyzed promotion of trauma-informed models statewide, including TF-CBT in outpatient settings and, in partnership with OCYF, implemented the sanctuary model of trauma informed care in 29 residential program sites (with a combined total of 2,397 beds).
 - OMHSAS' partnership with the PDE to offer prevention and early intervention services in schools through the statewide implementation of PBS. Nearly 100 schools have become involved in establishing PBS through this effort.
 - The initial establishment of HFW in six counties with a goal of preventing or shortening the residential placement and other intensive service use of Pennsylvania's highest needs youth. This is supported by the work of the Youth and Family Training Institute to provide training and credentialing oversight for HFW staff, in partnership with youth and family leaders, to ensure the youth and family voice and choice are foundational to this critical system reform. In support of this, OMHSAS worked with Mercer to develop a Medicaid-based funding approach for HFW to support its dissemination more broadly. Currently, nine counties are involved in implementing HFW, with nearly 300 youth and families being served. Significantly more youth and families will be served as the staff becomes fully trained and certified.
 - Under the lead of the DPW Bureau of Autism Services, there is increasing use of evidence-based approaches (such as applied behavior analysis) as a targeted intensive intervention for young children with ASD and improved assessment, through standardized requirements and training, using FBAs. Over 2,000 providers have received training through the Bureau of Autism Services (BAS) and MCOs in conducting FBAs and have been credentialed into provider networks by HealthChoices MCOs.
 - An FASD/Reactive Attachment Disorder (RAD) internal work group of the Children's Bureau was recently convened to strategize the most effective means to understand and identify the implications of these neurobiological disorders for both the individuals affected and the community in which they will receive treatment. The goal of the work group is to determine a set of guidelines inclusive of the needs of families, consumers, providers and community practitioners, as well as the available



- funding sources to provide education, treatment and prevention resources to those in need. The work group has identified the need for early identification and intervention building on protective factors. The provision of an early diagnosis, a stable, nurturing environment, and PCIT can all be effective in the prevention of the more serious secondary conditions, which can sometimes occur, such as criminal activity, homelessness, alcohol and drug abuse. At this time, the work group is concentrating its efforts on FASD, but also recognizes that a strategy for the Reactive Attachment Disorder will need to follow a similar process. The work group will be seeking stakeholder involvement to help complete both guideline documents and will continue to advocate for thorough and comprehensive evaluations, including a careful gestational history to ensure all factors are taken into consideration prior to a diagnosis.
- Pennsylvania's award in October 2009 of a federal grant to develop a statewide infrastructure in support of Systems of Care to serve youth with serious MH needs and their families, with particular emphasis on youth involved with the child welfare or juvenile justice systems and currently residing in, or at risk of, out-of-home placement. The \$9 million grant from the federal SAMHSA covers six years and will be implemented in 15 Pennsylvania counties.






Through these many local- and State-level initiatives, the Commonwealth has established a statewide foundation of many effective services, including:



- MST is now available at some level in 52 of Pennsylvania's 67 counties.
- FFT is available in 23 counties.
- Family Group Decision Making (FGDM) is available in 60 counties.
- Multi-dimensional treatment foster care is available in 12 counties.
- Incredible Years programs are available to young children and their parents in 13 counties to optimize parenting skills and prevent or minimize future difficulties.
- Early childhood MH consultation is available statewide to work within local daycare and preschool settings with those families whose children show early emotional and behavioral problems.
- A bulletin outlining the requirements for administration of FBAs in the HealthChoices program has been implemented to guide any BHRS prescription and treatment for youth with ASDs.

The map on the following page shows many of these initiatives across Pennsylvania counties, as of fall 2008, which encompasses the following initiatives (each of which is described, along with the primary symbol used on the map to denote it):

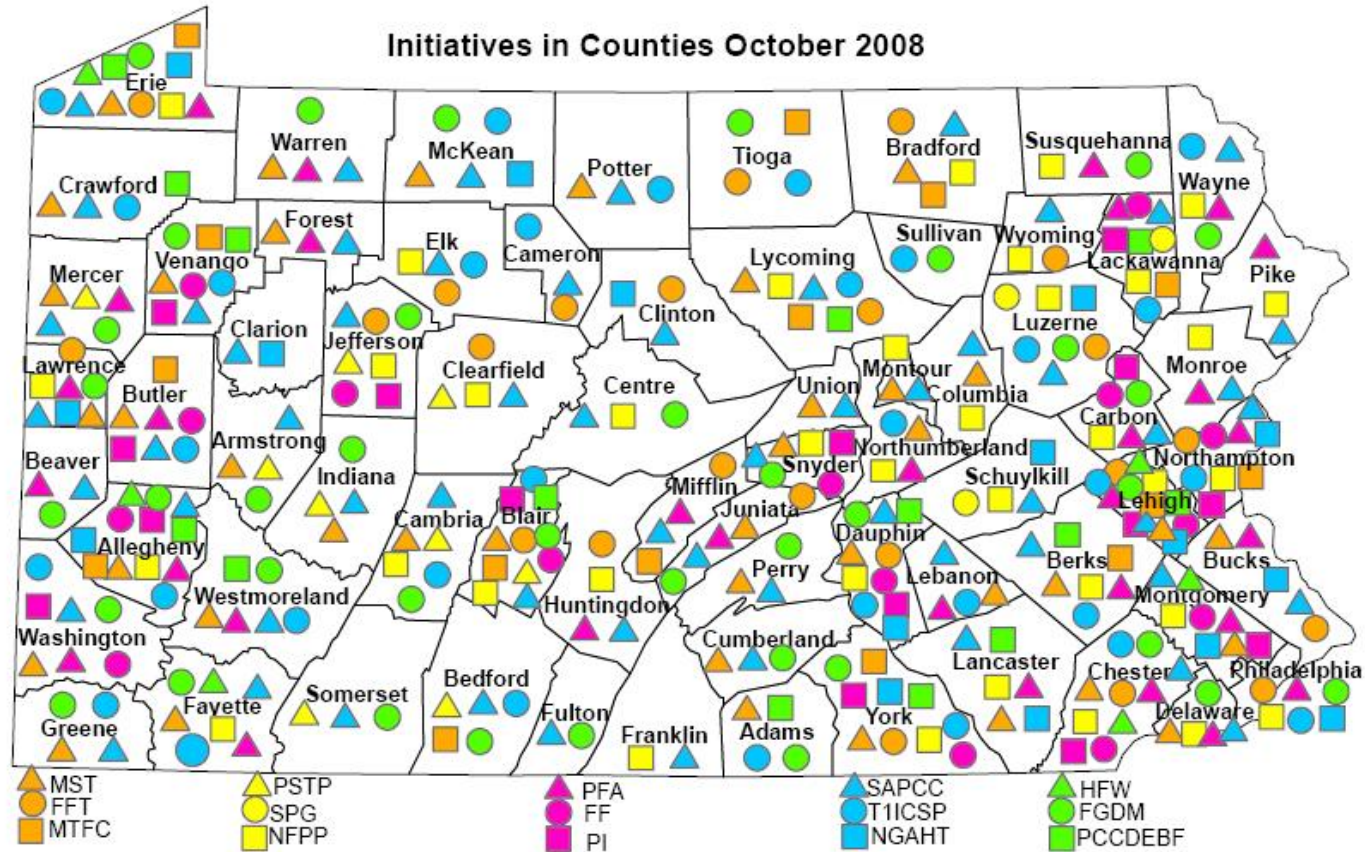
- The primary intensive, evidence-based service programs currently prioritized for development, include:
 -  Multisystemic Therapy
 -  Pelham Summer Treatment Program
 -  High Fidelity Wraparound
 -  Functional Family Therapy
 -  Multi-dimensional Treatment Foster Care
 -  Family Group Decision Making

- Prevention initiatives, include:
 -  Nurse Family Partnership Program
 -  Suicide Prevention Grant

- Cross-agency planning and EBP funding initiatives, include:
 -  Tier 1 ICSP initiatives (county-level cross-agency planning focus)
 -  PCCD Evidence Based Funding (juvenile justice focus)
 -  National Governor's Academy Home Teams (foster care focus)
 -  Permanency Initiative (child welfare focus)
 -  SAP County Coordination and/or SAP District Councils to coordinate implementation of school-based services such as Positive Behavior Interventions and Support (PBIS) and coordination with other child-, youth- and family-serving agencies

- Key supports for families:
 -  Paid Family Advocates
 -  Family Finding

While the programs and initiatives listed above and depicted on the next page represent a strong foundation on which to build, additional work remains.



▲ Multi-systemic Therapy	▲ Pelham Summer Treatment Program	▲ Paid Family Advocates	▲ SAP County Coordination and/or SAP District Councils	▲ High Fidelity Wraparound
● Functional Family Therapy	● Suicide Prevention Grant	● Family Finding	● Tier 1 ICSP	● Family Group Decision Making
■ Multi-dimensional Treatment Foster Care	■ Nurse Family Partnership Program	■ Permanency Initiative	■ National Governor's Academy Home Teams	■ PCCD Evidence Based Funding

Statistics on current services use

Today, nearly 170,000 children and youth receive BH services in the Commonwealth. The table below provides a breakdown of how many children were served by category of service in the three most recent State fiscal years (SFYs) available.¹⁵

Service recipients – Children under age 21			
Category of service	SFY 2006 – 07 total	SFY 2007 – 08 total	SFY 2008 – 09 total
Inpatient psychiatric	11,757	11,832	12,199
Outpatient psychiatric	108,022	114,762	123,468
RTF-accredited	5,058	4,652	4,209
RTF-non-accredited	1,593	1,322	1,298
Ancillary support	12,103	5,561	6,163
Other services	20,267	26,089	26,318
BHRS total	53,700	54,415	57,412
TSS	26,266	26,114	25,210
Mobile therapy	21,964	22,337	23,262
Behavioral specialist consultant	29,734	30,291	30,406
Other BHRS (including evidence-based supports such as MST and FFT)	44,557	46,244	49,838
Community support total¹⁶	27,033	28,222	31,003
Crisis intervention with in-home capability	4,908	7,224	8,238
FBMHS for children and adolescents	6,572	8,206	9,047
Targeted MH case management intensive case management and resource	15,242	18,483	20,179
Peer support services	22	40	63
Other community support	6,640	2	1
SUD services	10,749	12,216	13,380
Total unduplicated count of children served	149,651	157,372	168,555

¹⁵ The count of recipients within a category of service may be duplicated across the categories, but the totals within each single line represent a count of unique users.

¹⁶ For SFY 2006-07, all fee-for-service (FFS) Community Support data was reported as “Other Community Support”, due to data restrictions. In the latter two fiscal years, the FFS data was able to be distributed across subcategories. The trends between SFY 2006-07 and SFY 2007-08 are not comparable at a subcategory level for Community Support, due to this issue. The overall Community Support increase in this time period (from 27,033 to 28,222) is a more accurate indicator of the rate of increase.

Spending trends across those same categories of services are summarized below.

Expenditures – Children under age 21			
Category of service	SFY 2006 – 07 total	SFY 2007 – 08 total	SFY 2008 – 09 total
Inpatient psychiatric	\$101,070,885	\$106,891,183	\$113,821,509
Outpatient psychiatric	\$121,427,620	\$131,683,700	\$146,727,417
RTF-accredited	\$239,210,127	\$233,523,265	\$217,707,998
RTF-non-accredited	\$48,582,516	\$41,908,397	\$43,575,354
Ancillary support	\$1,151,770	\$777,812	\$706,465
Other services	\$16,200,439	\$21,495,496	\$24,644,137
BHRS total	\$575,421,059	\$582,268,839	\$617,371,827
TSS	\$303,880,602	\$281,977,537	\$274,563,811
Mobile therapy	\$54,068,285	\$54,829,517	\$61,327,568
Behavioral specialist consultant	\$105,084,411	\$107,028,787	\$117,199,414
Other BHRS (including evidence-based supports such as MST and FFT)	\$112,387,760	\$138,432,998	\$164,281,034
Community support total¹⁷	\$103,501,908	\$119,812,525	\$135,044,081
Crisis intervention with in-home capability	\$1,465,434	\$1,719,868	\$1,884,942
FBMHS for children and adolescents	\$62,024,650	\$77,386,688	\$88,848,260
Targeted MH case management intensive case management and resource	\$32,386,711	\$40,545,341	\$44,152,109
Peer support services	\$15,186	\$157,398	\$157,110
Other Community Support	\$7,609,927	\$3,230	\$1,660
SUD services	\$19,670,407	\$21,383,822	\$25,548,130
Total	\$1,226,236,731	\$1,259,745,039	\$1,325,146,918

Service spending for two subsets of children accounted for a disproportionately large amount of expenditures:

- Spending on services for children with ASDs accounted for 23.6% of all expenditures in SFY 2006 – 07, 26.4% of all expenditures in SFY 2007 – 08, and 28.7% in SFY 2008 –

¹⁷ For SFY 2006-07, all FFS Community Support data is reported as “Other Community Support” due to data restrictions. In the latter two fiscal years, the FFS data was able to be distributed across subcategories. The trends between SFY 2006-07 and SFY 2007-08 are not comparable at a subcategory level for Community Support, due to this issue. The overall Community Support increase in this time period (from \$103,501,908 to \$119,812,525) is a more accurate indicator of the rate of increase.

09, and these children represented 10.6%, 11.8%, and 12.5% of all service recipients under age 21 in these same years (respectively).

- Spending on services for Children in Substitute Care accounted for 24.6% of all expenditures in SFY 2006 – 07, dropping to 22.6% of all expenditures in SFY 2007 – 08, and dropping further to 20.8% in SFY 2008 – 09. During this same time period, these children represented 13.3%, 12.3% and 11.2% of all service recipients under age 21 (respectively).

In both years, most children served across all categories of service and diagnoses were male (61% in all three years). The range of ages served was also largely consistent in the three most recent fiscal years, as summarized below.¹⁸

Age group	SFY 2006 – 07 percentage	SFY 2007 – 08 percentage	SFY 2008 – 09 percentage
0 – 1	0.5%	0.6%	0.6%
2 – 6	14.9%	15.3%	15.6%
7 – 12	35.5%	35.4%	35.3%
13 – 17	35.9%	35.1%	34.1%
18 – 20	13.2%	13.7%	14.5%
Total	100.0%	100.0%	100.0%

¹⁸ Percentages are for those children with data reported only. In each year, there were a small proportion of children for whom data on age was not reported in the available databases (280 in SFY 2006-07, 252 in SFY 2007-08, 159 in SFY 2008-09).

A breakdown by race and ethnicity is provided in the table below.¹⁹

Race	SFY 2006 – 07 percentage	SFY 2007 – 08 percentage	SFY 2008 – 09 percentage
African American/Black	24.9%	24.1%	23.8%
American Indian	0.2%	0.1%	0.2%
Asian, Hawaiian or other Pacific Islander	0.5%	0.5%	0.6%
Hispanic ethnicity ²⁰	3.3%	3.5%	3.9%
Other (or not volunteered)	11.1%	11.8%	12.4%
White	63.5%	63.6%	63.2%

A remaining challenge: moving resources to more effective practice

The challenge facing the Commonwealth is how to build on the current service array to develop a true System of Care that is responsive to the diverse strengths and needs of Pennsylvania's families and children. Research on implementation of EBPs describes the complex constellation of policy, procedural and funding mechanisms needed, in concert with favorable organizational cultures and a supportive external funding and regulatory climate, to support the robust establishment of successful practices.²¹

The scope of the challenge can be seen in a recent analysis of BH service funding trends. There has been significant progress in shifting the Commonwealth's limited resources toward more evidence-based and family/youth driven services and shifting resources away from more restrictive services, such as the broad use of RTF services and TSS.

¹⁹ In combining person level encounter (PLE) data from HealthChoices with FFS data, there was some variability in how data on race and ethnicity was assigned (for example, a child might identify as Asian American in one database and "Other – not volunteered" in the other). This will lead to some minor duplication in the specific counts, but this should not affect the overall breakdown proportions.

²⁰ Hispanic ethnicity is tracked separately from race in the databases, so persons who identify as Hispanic may also identify their race as African American, Hispanic, White or any other racial option. As a result, including the Hispanic ethnicity data in this table introduces some level of duplication and the column totals exceed 100%. The table is best understood as the percentage of persons who choose any of the other race options besides Hispanic, plus the persons who endorse the Hispanic ethnicity option.

²¹ Fixsen, et al. (2005). Previously cited.

5

Where do we go from here? Next steps in working toward the ideal array of behavioral health services for youth and families

As a framework for the continued transformation of the children's BH system, OMHSAS recently identified a set of prioritized next steps for children's BH service development over the next four to eight years. The following outline was drawn from the work of the OMHSAS Children's Advisory Committee, supplemented by information from the many current initiatives described earlier in this report. While these steps will need to continue to evolve in order to respond to emerging policy changes related to MH Parity and health care reform, the potential next steps most evident, currently include:

1. **Develop a public health approach** to children's BH: The public health model emphasizes promotion of mental wellness, as well as the prevention of MH problems. The Institute of Medicine has identified three levels of prevention activities:
 - i. Universal, which is proactive, has no stigma attached and is available regardless of risk status.
 - ii. Selective, such as preschool programs for all children in impoverished neighborhoods and support groups for children who have experienced trauma.
 - iii. Indicated prevention for individuals who have symptoms at a level of severity that can be mitigated before more full-blown conditions develop.

A variety of current evidence-based models such as PBIS and primary care-based medical homes incorporate these principles, and the overall System of Care movement seeks to integrate services for children, youth and families with the highest needs within a coordinated array of supports, grounded in a commitment to prevention and resiliency.

2. **Develop ECMH services:** Steps are being taken to build on the rapidly developing knowledge of infant and young child development. Initiatives, such as workforce development and MH consultation to early care and learning centers can and should be enhanced and expanded.
3. **Develop a service system that is family-driven and youth-guided:** The Systems of Care initiative and the development of HFW are two key constructs to the future of children's BH services. Both look to support children with multi-system and complex needs, use family and natural supports, build on strengths and the resiliency of children and utilize peers for transition age youth.
4. **Improve and expand the EBPs** that comprise the ideal service array: Research has shown that there are many effective approaches to addressing children's BH needs. Several such programs have been implemented in Pennsylvania through collaboration between OMHSAS, OCYF and PCCD. The public system can provide incentives for these proven approaches, including monitoring and improving access to existing EBPs and expanding as appropriate.
5. **Expand school-based BH:** Social, emotional and behavioral development are essential for academic achievement. The expansion of PBS, as well as school-based BH services, is a way to accomplish this fundamental public policy goal.
6. **Restructure residential treatment:** Residential treatment should be provided less often, with a goal of a 50% reduction from baseline trends. The residential treatment that is provided should be more intensive, short-term, clinically-effective and community-based. Supportive efforts, such as trauma-informed care, alternatives to coercive techniques and reduction of out-of-state placement are essential components.
7. **Expand services to youth with substance use problems and co-occurring issues:** There is a need to address the systemic issues that inhibit early identification, coordination of treatment and follow up.
8. **Assist transition-age youth and young adults to develop the skills and assets** necessary to be successful in adulthood. Specific action includes:
 - Development of a system of BH services for transition age youth and young adults in every county.
 - Psychiatric rehabilitation specific to the transition-age population.
 - Options to address the housing needs, vocational needs and social development of transition-age youth and young adults.
9. **Coordinate and braid efforts across agencies.** In order to fill in the gaps identified previously, the child-serving agencies of DPW, along with other agency partners at the State (e.g., PDE and JCJC) and county levels will need to continue and enhance their collaborative cross-system work. To reduce the overuse of residential

treatment, OMHSAS, OCYF, the juvenile justice system and schools will need to work together to:

- Increase the use of an increasing array of community-based EBPs.
- Increase the use of short-term, non-institutional out-of-home placements.
- Increase their focus on trauma-informed interventions within all services and levels of care, as it has become increasingly evident that traumatic stress plays a role in the lives of many children who are served by all of these agencies.
- Support data collection, training and fidelity to promising and emerging practices that show State- or community-specific success.
- Support the availability of flexible funding and family support services to facilitate individualized, family-driven and youth-informed planning processes that are grounded in natural supports.
- Increase recruitment and/or retention of 1) child/adolescent psychiatrists, 2) providers well-versed in EBPs, 3) youth and family peer advocates, 4) providers with specialized expertise in working with diverse cultural and linguistic populations and 5) youth and families committed to offering their knowledge, guidance, support and strong voices to all aspects of DPW that will affect Pennsylvania's youth.

10. Incorporate the changes emanating from health care reform. Over time, the Patient Protection and Affordable Care Act of 2010 will extend health insurance coverage to the uninsured, allow young adults to remain on family insurance plans until age 26 and require that insurance companies no longer reject individuals with pre-existing medical problems, including MH problems. It will also expand the reach of the 2008 MH Parity law, which requires that insurance companies impose no greater restriction, in terms of cost or limitation on access to treatment, for MH conditions and substance abuse disorders than for all other medical/surgical procedures. There is the potential in these reforms for additional community-based prevention and wellness services, funding for early childhood home visitation and funds for school-based health clinics, all of which would have significant implications for children's BH.

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