

**Department of Human Services
Addictions & Mental Health Division**

**CHILDREN'S MENTAL HEALTH SYSTEM
2007-2009**

SUMMARY AND OVERVIEW

September 8, 2009

This document summarizes 2007-09 efforts by AMH to bring the children's mental health system to a functional and valuable level, where children and families are respected, treatment is effective, and the possibility of a future without limitations exists.

The Addictions and Mental Health Division of the Department of Human Services is dedicated to promoting children's mental health. Specifically, the Division is focused on

- ◆ early childhood services that are appropriate, timely and preventative,
- ◆ a treatment system that functions effectively and in a coordinated manner for those who seek public mental health treatment,
- ◆ maximizing responses to children's unique behavioral concerns that are humane and respectful of children, based on a belief that children are inherently good,
- ◆ creation of a service delivery system that allows for a meaningful and developmentally appropriate transition to adulthood in all its aspects, and
- ◆ integration of services and supports from multiple child-serving systems to further the ability of children, youth and families to recover and lead meaningful and productive lives.

Children's Mental Health is a substantial concern to Oregonians. The cost of services for children and youth who do not get timely treatment and assistance for trauma and trauma induced disorders, biological disorders, and who experience emotional and behavioral challenges, is compounded over time. These children, without appropriate intervention, can become adults who battle chronic mental illness. The cost to individuals, families and society is enormous.

Children and youth with mental health conditions being served in the Juvenile Justice system, those with co-occurring substance use and mental health disorders, children in foster care with repeated and frequent disruptions in their placements,

children being served in facility-based care whose stay exceeds their individual need, and those who are homeless or who have dropped out of school are only some of the young people whom the system fails.

Other children in need of support from the children's mental health system include those born with "built-in" challenges in life such as a physical or developmental disability or those with a sibling with significant health care needs, or a parent who is not physically or mentally healthy. From a young age, these children are usually aware that they are different from other children. Their level of natural resilience, or lack thereof, can make all the difference, as can support and education.

It is only in perhaps the past two decades that children's mental health and treatment needs have been seriously considered. There is still significant stigmatization that occurs for children and their families¹. Treatment systems are cumbersome and difficult to navigate to find necessary services. System reform is beginning to occur, but takes time, resources and expertise that is not widespread.

Improved Family Satisfaction

During the second and third years of the transition to a new system of services and supports (Children's System Change Initiative-CSCI) for children, there has been an improvement in parent and caregiver satisfaction with the coordination of mental health services, educational services, juvenile justice services, Oregon Youth Authority services and child welfare services (Source: 2007 and 2008 Youth Services Survey for Families).

Improvement in coordination of services is important because, thirty-three percent of families who receive mental health services must coordinate with three or more service systems (child welfare, developmental disabilities, juvenile justice, schools, alcohol and other drug treatment, Oregon Youth Authority) in addition to mental health to effectively obtain the types and mix of services their child needs.

¹ A recent national survey of family members conducted by Portland State University revealed that **81% reported experiencing stigmatization** –being treated negatively or unfairly because of their child's emotional or mental health condition. The most frequent sources of the negative treatment, according to the research, were school personnel and people in the community.

Family perception of outcomes from 2007 Youth Services Survey for Families demonstrated that 76% or more were involved in their children's treatment and overall, 65% or more felt services were appropriate.

Changes in the System

Statewide Wraparound Initiative

The Statewide Children's Wraparound Initiative continues through legislation, formation of a Project Management Team, and development of an Implementation strategy. Subcommittees have addressed Information System Assessment, Market Assessment, Services and Supports, Fiscal Sustainability, Training, Evaluation and Accountability, and Agency Strategy. A final report was drafted in June 2009 detailing the recommendations of the Project Management Team utilizing the work of the subcommittees.

HB 2144 (Statewide Children's Wraparound Initiative) passed the 2009 Legislature. It mandates that state agencies develop a system of care and that interagency pooling of resources take place. System of care values and principles are a critical part of the legislation.

The Children's System Change Initiative (CSCI) was implemented in October 2005. A qualitative evaluation was conducted by Portland State University /Regional Research Institute (PSU/RRI) in late 2006. In 2008, in response to stakeholders' requests, AMH conducted a series of Focus Groups in each geographic region corresponding to the seven mental health organizations to make mid-course revisions in the implementation. Communities have begun using the information gained from these focus groups to plan needed changes. Statewide reporting on the themes from these focus groups occurred in March 2009.

In addition, AMH has several other areas of focus for ongoing system improvement:

Focus on early childhood mental health

- Availability of Oregon Health Plan treatment guidelines for children birth through age five for specific mental health diagnoses when the children would not meet the full criteria for DSM diagnoses because of their developmental status.

- Four counties are implementing the evidence-based practice Parent Child Interaction Therapy (PCIT) and establishing a local and statewide training program including training for a therapist from an identified cultural, ethnic or linguistic community.
- Initial work to implement use of the Early Childhood Service Intensity Instrument (ECSII) for determining the mix and intensity levels of services for children from birth through age 5 is occurring.
- Participation on the Oregon Early Childhood Council and Health Matters Committee to: 1) Provide all young children and their families with a regular source of coordinated, comprehensive, quality healthcare through improved early childhood linkages with health system and health care reform efforts, 2) Promote social-emotional development in all early childhood settings by developing statewide availability of health and mental health consultation to providers serving young children and their families. 3) Identify and address health & behavioral health risks and conditions as early as possible.

Active partnership with Children Adults and Families (CAF-child welfare)

AMH has been actively partnering with Children Adults & Families (CAF) to improve the local and state linkages between mental health and child welfare services and supports. These linkages are crucial in efforts to provide earlier and more effective intervention, especially in identifying children experiencing trauma and in providing trauma-informed treatment. Early intervention in trauma-induced symptomatology has been shown to be pivotal in mitigating the negative effects of trauma on critical periods of brain development².

AMH has partnered with CAF on the following projects during the 2007-2009 biennium: 1) Psychotropic Medication Management for Children in Foster Care; 2) Development of a Memorandum of Understanding on Mental Health 3) Assessments for Children in Foster Care that outlines policy, development of local protocols, and data analysis in rates of assessment; 3) Maintaining MHO enrollment for continuity of care for children in Behavioral Rehabilitation Services (BRS) placements; and 4) Development of Intensive Community Care placements within BRS which also incorporates Treatment Foster Care and Intensive Community-Based Treatment Services(ICTS).

² McGowan, P., et al., (2009) Epigenetic regulation of the glucocorticoid receptor in human brain associates with childhood abuse. *Nature Neuroscience* 12, 342 – 348.

Implementation and Sustainability of Collaborative Problem Solving Model

In 2007 the Collaborative Problem Solving (CPS)³ model was first introduced in Oregon. Research in the neurosciences supports the Collaborative Problem Solving model. Children with severe emotional and behavioral challenges often lack critical skills in areas such as problem solving, frustration tolerance and the ability to be flexible. The basis for this approach requires a significant change in how the needs of children with severe emotional and behavioral challenges are understood.

Oregon has achieved important goals for statewide implementation and sustainable practice of CPS, an approved Evidence-Based Practice in Oregon. In 2007 two conferences were held to conduct baseline training in the model. In 2008 AMH offered 12 scholarships throughout Oregon to multiple child-serving agencies that provided financial and technical assistance to schools, residential and foster home providers, community and residential mental health providers, addiction services and parents. Early data from two CPS settings, Emanuel Hospital's Child & Adolescent Psychiatric Unit and Pioneer Special School (K-6), both in the Portland metropolitan area, show significant improvement in reduction of behaviors leading to and the actual use of seclusion and restraint.

Children's System Change Initiative Update

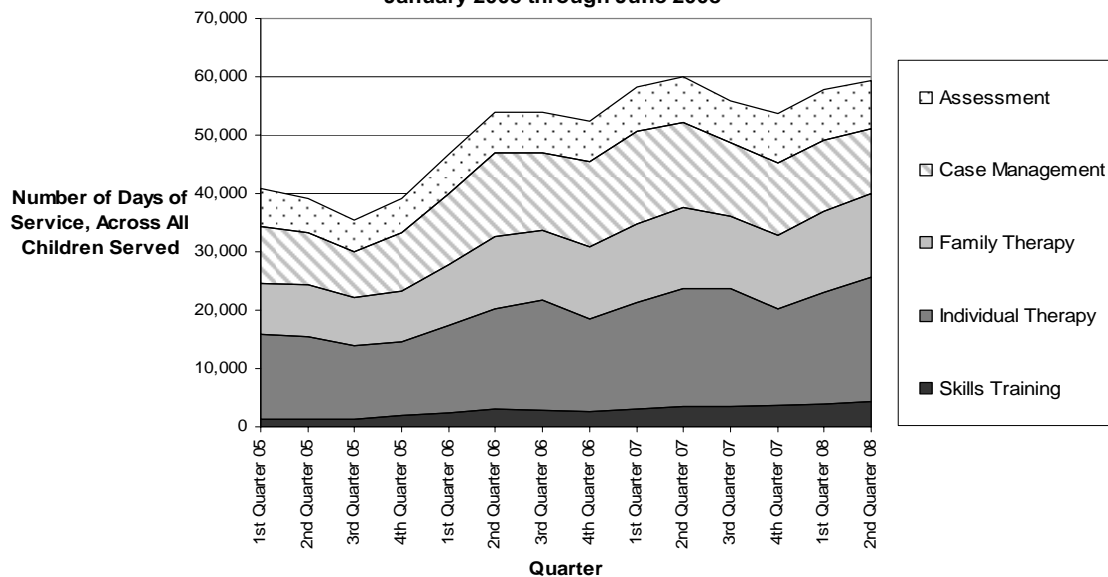
Service Utilization Increases in Community Settings

Each community has a uniform level of need determination process that is adhered to. The primary source of referral for a level of need determination in most communities comes from a mental health provider or child welfare worker. Other referral sources are educational providers, parents, and juvenile justice officers. Children with high needs, and their families, experience a dramatic increase in the breadth and frequency of community-based mental health services following a level of need determination.

During the second and third years of the transition to a new system of services and supports (CSCI) for children:

³ Ross Greene M.D. and Stuart Ablon Ph.D. are co-developers of the CPS model.

**Figure 2. Trends in Provision of Children's Outpatient Mental Health Services by MHOs:
January 2005 through June 2008**



1) MHO enrollment of children has increased significantly. At the end of 2007 the number of children enrolled in an MHO under age 17 was 217,583, or approximately 25% of the child population in Oregon.

2) Rates of children being served have fluctuated over the past year, but, since 2005 the trend has been toward more children receiving mental health services.

3) Children are being screened for and served within the Integrated Service Array according to a standardized level of need determination protocol for their mental health service needs. Of the children treated in the Integrated Service Array, 42% were treated in facility-based care and 58% were treated in community-based settings.

Prior to the CSCI, nearly all of these children now being treated in community-based settings were treated in facility-based care. Intensive Community-Based Treatment and Support Services (ICTS) are being provided to 2,922 children⁴ entering the Intensive Service Array. This includes a child and family team, care coordination and integrated services.

4) All children with mental health needs, and their families, who went through a level of need determination process received a dramatic increase in the breadth and frequency of community-based mental health services. 88% of children screened were recommended for entry into the Integrated Service Array.

5) In 2007, of the 34,617 children being served in the public mental health system, 90% were served in a community setting rather than in a psychiatric day treatment or residential treatment setting. The types of services they received in the

⁴ Numbers are from Client Process Monitoring System, and do not reflect completely unduplicated counts.

community could include intensive outpatient, wraparound, care coordination, skills training, respite care or crisis respite care⁵.

Facility Based Care

In the second and third years of the transition to a new system of services and supports (CSCI) for children: 1) The number of children admitted to a Psychiatric Day Treatment Setting (PDTS) decreased by 25%. The number of admissions to PDTS decreased from 243 (in the 4th quarter of 2006 and the 1st quarter of 2007) to 181 (in the 4th quarter of 2007 and the 1st quarter of 2008). 2) The number of children admitted to a Psychiatric Residential Treatment Setting (PRTS) decreased by 34%. The number of admissions to PRTS decreased from 349 (in the 4th quarter of 2006 and the 1st quarter of 2007) to 229 (in the 4th quarter of 2007 and the 1st quarter of 2008).

Decreasing admissions to PDTS and PRTS, while a positive sign of the diversification of the service array, jeopardizes an already destabilized fiscal picture for psychiatric providers. Residential and day treatment providers are being challenged to diversify their services to remain viable in the marketplace.

The system has been seriously under resourced relative to need. Providers are unable to pay a competitive, livable wage to staff working with the children. The result is that less experienced and upwardly mobile clinicians are moving on once experience has been gained. Recent statewide focus groups held regarding concerns about the implementation of the Children's System Change Initiative underscored the problems of staff turnover and its impact on care delivery.

Development of Family/Youth Involvement

There are 16 family members participating at a leadership level and conducting trainings of other family members in family driven services and family involvement. There are 116 family members and 26 youth trained to participate in advisory councils, planning groups and workgroups since the Children's System

⁵ The array of services included under the rubric of "Intensive Community Based Treatment and Support Services (ICTS)" has changed since initiation of the Children's System Change Initiative (CSCI). Thus, comparing the number of children in the Integrated Service Array who received ICTS before versus after the CSCI is not meaningful.

Change Initiative was launched. Fifty-one family members and 14 youth are involved in advisory councils at the local, regional and state levels. 11 family members are hired/ subcontracted with MHOs, community mental health programs and other providers, affording local family involvement coordination and leadership.

All 9 Mental Health Organizations in the state have a Children's System Coordinator. Care coordination is available and provided throughout the state in every county. However, developing the availability of adequate numbers of care coordinators, and training both care coordinators and their supervisors is still a pressing need and caseloads are very high in many communities. In 2006, the PSU researchers evaluating the CSCI indicated that most mental health organizations in Oregon would need 3 additional care coordinators added to their region to reach caseload ratios (1:15) recommended by federal research findings.

Every MHO has a children's system advisory council with varying levels of family member representation. Assuring 51% family member involvement on advisory councils has been challenging. Barriers include transportation (especially in rural areas), locating, recruiting and retaining family members, unwieldy numbers of council members in larger MHOs, and difficulty ensuring participation by family members who may have scheduling, child care, transportation, and other family related needs.

AMH has contracted with the Oregon Family Support Network to develop a curriculum and train family members as Family Navigators. Family Navigators are family members of children with mental health challenges who are specifically trained to guide other families in their search for appropriate services in their own community. Family Navigators are currently hired in three county pilot sites.

Services for Young Adults in Transition

AMH is working to address services for young adults ages 14 to 25 who are leaving the children's mental health system and need services from the adult mental health system, in addition to services for young adults experiencing the first indications of a major mental illness. Oregon was one of six states selected to participate in a Policy Academy sponsored by Substance Abuse and Mental Health

Services Administration SAMHSA) and Georgetown University in December 2008.

The Policy Academy focused on developing a work plan that will create a service delivery system for young adults with mental health challenges that is developmentally appropriate, young adult driven and focused, and more seamless in transition. This policy group meets monthly to continue the work started at the Academy. Strategies are being used in identifying and mitigating barriers to eligibility, outreach and strategies for collaboration at the state and local levels.

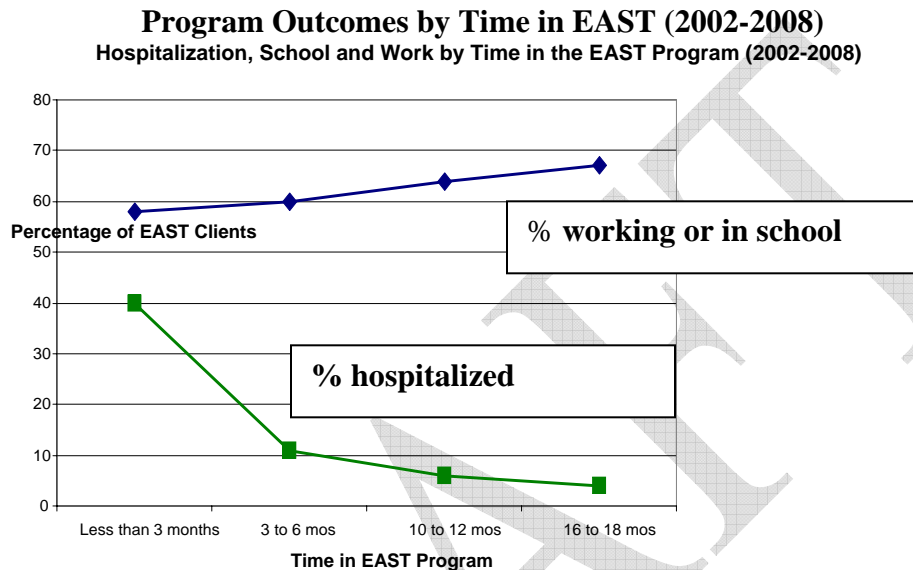
The 07-09 bi-ennium saw the introduction of two residential sites focused on Young Adults in Transition. These programs, managed by ChristieCare and Trillium, have provided desperately needed services to this under-served population. Additionally, a few supported housing programs, such as Portland's Empowerment Initiatives, have also come on line and are providing linkages to community reintegration.

It should be noted that each of these projects upon opening immediately experienced a growing wait list that has not eased with time. Expansion of these types of programs can lessen gaps within our current system that lead to homelessness and a transitory lifestyle in the young adult population. Caseload growth funds are earmarked for increasing the service array in the next biennium.

EASA is the statewide dissemination of the EAST Program (Early Assessment and Support Team). The EAST Program supports EASA sites in Clatsop (Project Intercept), Columbia, Crook, Deschutes, Hood River, Jefferson, Linn, Marion, Multnomah, Polk, Sherman, Tillamook, Wasco, Washington, and Yamhill Counties. All teams report that they are using hospitalization and crisis resources less.

EASA teams provide community education, proactive outreach and engagement, medical and psychosocial assessment treatment, vocational and academic support, and family support with training with technical support from EAST to teens and young adults who have recently developed symptoms of schizophrenia and related psychotic illness, such as hallucinations, delusions and inability to process information.

EASA participants are succeeding in school, work, and community involvement. EASA supports families, and prevents unnecessary suffering and disability. As of December 2008, EASA programs were serving approximately 180 families. The program is based on international research of successful approaches to addressing early onset psychosis symptomatology.



Summary

It is essential that community partners work together to insure that services and supports are provided in a timely, early, and successful manner to improve the emotional well-being of Oregon’s children and families.

Awareness of the critical importance of Children’s Mental Health services and supports in our state must become commonplace. The importance of continuing work on integration and coordination efforts between system partners is also imperative.

There are many challenges and opportunities for Oregon to improve services and supports and emerge as a national leader in Children’s Mental Health treatment delivery. The challenge of removing barriers to the creation of a system of care, where “siloed” services no longer occur, is real, but can be accomplished with the energy, determination and will of all of Oregon’s child-serving agency representatives.