BEFORE THE BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

RESOLUTION NO. 02-034

Adopting Recommendations from the Child and Family System of Care Phase II Workgroup for Children's Mental Health System Redesign

The Multnomah County Board of Commissioners Finds:

a. The Child and Adolescent Workgroup of the Mental Health Design Team issued a final report in September 2000 that detailed recommendations to create an integrated mental health system of care for children and families.

b. The Child and Family System of Care Phase II Workgroup was convened in November 2001 to make recommendations to the Multnomah County Board of Commissioners for the implementation of the Children's Mental Health System redesign.

c. The Board of Commissioners subsequently adopted Resolution No. 01-153 which provides the Values and Principles to guide the Children's Mental Health System redesign.

d. The Child and Family System of Care Phase II Workgroup concluded its work in January 2002 and issued the attached report.

The Multnomah County Board of Commissioners Resolves:

1. The January 29, 2002 Final Report of the Child and Family System of Care Phase II Workgroup is adopted.

ADOPTED this 7th day of March, 2002.

BOARD OF COUNTY COMMISSIONERS
FOR MULTNOMAH COUNTY, OREGON

Diane M. Linn, Chair

REVIEWED:

THOMAS SPONSLER, COUNTY ATTORNEY
FOR MULTNOMAH COUNTY, OREGON

By _____
Katie Gaetjens, Assistant County Attorney

Child and Family System of Care Workgroup

Recommendations

for Children's Mental Health Redesign

Final Report – 01/29/02

I. Background

The Child and Adolescent Workgroup of the Mental Health Design Team final report in September 2000 recommended a developmental model of mental health intervention for children, adolescents and their families. Prevention and early intervention would be provided for those at risk of later involvement with the mental health system, and intervention would be based on age-appropriate outcomes within context of the family system. The report detailed recommendations to create an integrated system of care, broaden access to developmentally appropriate and comprehensive services, and unify the mental health system's structure.

A Child and Family System of Care Workgroup was subsequently convened by Commissioner Lisa Naito, to focus recommendations for the Department of Community and Family Services on Phase II and III of the Multnomah County Mental Health Redesign.

Goals adopted by the Workgroup were: children and families have access to a continuum of services in a timely manner, children and families have the ability to chose among services and providers; contracts for providers assure adherence to the System of Care Values and Principles; and providers coordinate services with other systems on behalf of consumers.

The Workgroup recognizes that much is right in our current children's mental health system: we have excellent services available; we have made great progress in delivering services in schools and other natural settings; and our community has come to recognize the mental health needs of young children. However, we have challenges, too. Our system is not serving all children who have needs, due to the combination of inadequate funding, gaps in services, capacity and quality, and lack of access and referral. There are large gaps in service for some ethnic or cultural groups. Parents too often are not fully included in planning for their child's care. The overall system is fragmented, lacks coordination, and doesn't adequately promote early care, often resulting in a crisis situation before the need for care is addressed.

The strength of our Child and Family System of Care in Multnomah County is that we recognize the need to work together to address these issues. The recommendations in this report will be presented to the Department of Community and Family Services, to use in the development of their Mental Health Redesign Plan for children. These recommendations also can serve as a framework for all partners in our Child and Family System of Care as we work toward our goals.

II. System of Care Values and Principles

On November 29, 2001, The Board of County Commissioners for Multnomah County adopted Values and Principles for Child and Family Mental Health System Redesign*, as recommended by the Child and Family System of Care Workgroup. (Bold type is added.)

A. Values

1. The system of care will be **child centered and family focused** and the needs of the child and family determine the types and mix of services provided.
2. The system of care will be **community based**. Service management shall be individualized.
3. The system of care will be **culturally competent**. Agencies, programs, and services will be responsive to the cultural, racial, and ethnic differences of the children and families they serve.

B. Principles

1. Child mental health consumers and their families will have access to a **comprehensive array of services** that address their physical, emotional, social, and educational needs.
2. Child mental health consumers and their families will receive services in accordance with the unique needs and potentials of each child guided by **individual service plans**.
3. Child mental health consumers and their families will receive services within the **least restrictive most normative environment** that is clinically appropriate.
4. The families and surrogate families of children with mental health disorders will be **full participants** in all aspects of the planning and delivery of services.
5. Child mental health consumers and their families will receive **integrated services**. Child-serving agencies and programs will be connected with planning, development, and coordination of services.
6. Child mental health consumers and their families will receive case management or other services so that **multiple services are delivered in a coordinated and therapeutic manner**, and that services meet their changing needs.
7. **Early identification and intervention** for children with emotional, behavioral or mental disorders and their families will be promoted to enhance the chances of positive outcomes.
8. Children with mental health disorders should be ensured **smooth transitions** to the adult service system as they reach maturity.
9. The **rights** of children with emotional, behavioral and mental disorders **will be protected and effective advocacy** for children and adolescents with such disorders will be promoted.
10. Child mental health consumers and their families will **receive services without regard** to race, religion, national origin, sex, physical disability, or other characteristics, and services will be **sensitive and responsive to cultural differences and special needs**.

*These are adapted from CASSP Principles (Child and Adolescent Service System Program) as published in Stroul & Friedman's, A system of care for children and youth with severe emotional disturbance, 1986. Some language has been changed to be more inclusive of family involvement and to address children of all ages with a wide range of mental health risk factors and disorders.

III. Recommendations for All Children

The Child and Family System of Care Workgroup recognizes that it is important to deliver services based on the strengths of the child and family. The mental health service system for children should therefore respond to children within context of how the child lives – in a family, involved in childcare or school, and as part of a culture and community.

Parents, or other primary caregivers, have a special role in developing and participating in their child's treatment plan. Throughout this report, "parent" will mean the responsible caregiver for a child, whether: both parents, a single parent, a grandparent or other relative, foster parents, or another person with custody of the child.

Children live in diverse families and cultures. To be effective, mental health services must be appropriate to the language, culture, community and values of the family and child.

A primary goal of mental health services for children is to help the child develop and thrive mentally, emotionally and behaviorally. This growth process needs to be encouraged, anticipated and planned for in mental health service delivery. Services should be delivered in the most natural, least restrictive and most appropriate setting to meet the needs of the child and family.

Because most preschool age children are involved in some type of out-of-home care, and the public education system has a responsibility for children over age 5, involvement of childcare and education systems in identifying children's needs and participating in treatment is essential. Research shows that delivering mental services in a school setting improves access for children and families.

In addition, most children receive health care through family practice physicians, pediatricians, County Health Clinics, or other settings. Health providers can assist families to identify and refer for mental health assessment and services, or offer mental health services on-site.

Many children or their families are involved in other systems as well. Coordination with these systems (such as addictions services, child welfare or corrections) is needed, as well as assistance to obtain services to meet the child or family's needs (such as adequate income, employment, housing, or food).

Recommendations for All Children:

A. Child and Family Focused

Services should be easy to locate and easy to get into; the type and mix of services should be based on the needs of the child and family. To accomplish this:

1. Improve **access to mental health services** for children, youth and their families.
    a. Educate youth and families about mental health services and how to access them.
    b. Provide outreach, education and early intervention specifically for children and youth.
    c. Enhance the Call Center's ability to respond to youth and families, by adding staff with children's expertise and increasing multi-lingual/multi-cultural staff.
    d. Inform families of the availability of culturally specific and linguistically appropriate services.
    e. Develop community awareness of mobile crisis unit's service for children in crisis; strengthen mobile crisis coordination with children's providers;

develop other crisis services in keeping with value of reaching out to all in need.

f. Develop walk-in clinic services that are comfortable for children, youth and families.
g. Assure that providers meet access requirements, including no-appointment necessary or other means for meeting urgent needs, and non-urgent new service within 2 weeks of the request.
h. Provide for immediate access to services for children, with no waiting lists or gaps in service availability.
i. Provide for a seamless transition from Oregon Health Plan (OHP) to non-OHP services.

2. Increase **family involvement in** treatment planning and coordination of care.
    a. Support the parent as a full participant and equal partner in treatment planning, with a goal for the parent to assume as much of the coordination role as they are able.
3. **Empower families** with information, support and training.
    a. Use strategies such as family support groups, training sessions, and assistance of family members, to help inform and engage other families in clinical treatment.

B. Community Based

Community based services and individualized service management should form the foundation for prevention, early intervention and treatment. To accomplish this:

1. Continue **prevention, outreach and early intervention,** using a public health model.
    a. In collaboration with community partners, continue to provide pre-diagnosis consultation, education, screening, child and family support, and early intervention to optimize treatment outcomes, and to identify child and family needs and refer for appropriate treatment.
2. Promote **natural settings** as the preferred location for clinical services.
    a. Promote selection of setting based on the child and family's needs and preference, e.g. childcare, schools, family homes, other community settings, or clinics.
    b. Realign treatment practice through incentives, training and quality management.

C. Culturally Competent

Reaching and effectively serving children from Multnomah County's increasingly diverse cultural, racial and ethnic membership is a major work area for the County and the community. The system should be responsive to cultural preferences and needs from outreach to families, through the provision of services to meet each child and family's needs. The Surgeon General's recent recommendations* on eliminating racial/ethnic and socioeconomic disparities in access to services, suggested co-locating services with other key systems, and strengthening the capacity of schools as a link to meet the needs of youth and their families where they are. To accomplish this:

1. Increase **multi-lingual/multi-cultural staffing**, leadership and volunteerism throughout the system, so that minority children and youth are assessed and diagnosed appropriately, and treatment and support are sensitive to multi-cultural issues.

2. Map current service and demographic information; **identify underserved ethnic groups** and gaps in services; develop culturally competent resources or implement outreach plans to **increase numbers of children and youth served** from these groups.
3. Identify **effective treatment modalities** and best practices for reaching and serving cultural, racial and ethnic groups; incorporate these into provider's practice.

*See "Report of the Surgeon General's Conference on Children's Mental Health, A National Action Agenda", DHHS, September 2000. Recommendations of the report include improving: public awareness, assessment and recognition of needs, access and coordination, and use of scientifically-proven prevention and treatment services.

D. Comprehensive Array of Services

A comprehensive array of services should be available to address children's and families' physical, emotional, social, safety and educational needs, with services appropriate for each age group: early childhood, school-age children, and teens/youth. To accomplish this:

1. **Fill gaps** in the continuum of services for children and youth.
    a. In cooperation with providers, identify current service capacity and gaps, and build a more comprehensive array, include cultural competency throughout this process.
    b. Contract and develop partnerships with the full range of providers, including acute and residential; no single provider currently offers a full range of services for children.
    c. Develop a specific plan and enhance resources to serve high-need children.
    d. Increase acute care alternatives for children, such as therapeutic respite care.
    e. Expand availability of respite care to families.
    f. Improve crisis response for children and youth.
    g. Incorporate and integrate services with addictions services for youth.
    h. Improve access to voluntary services for traditionally underserved populations to address minority over-representation in involuntary systems.
2. **Assure flexible services** to meet individual child and family needs.
    a. Develop ways for the system to maintain and increase flexibility to allow the plan of care to specifically address the needs of the child and family.
    b. Promote facilitating access to supportive, community and wrap-around services, including those not reimbursed by the Oregon Health Plan (OHP).
    c. Through training and system development, expand beyond the appointment-based service model toward family and home-based models, in natural settings such as childcare and schools, and implement other evidence based best practices.
3. **Customize delivery systems** as needed for each age group: early childhood, school age, and teens/youth.
    a. Develop appropriate incentives for providers to serve children with intensive needs in each age group.
    b. Recognize the different developmental stages of children, and that natural settings and needs may change significantly with the child's age.

E. Integrated, Coordinated Services

For children involved in the mental health system, there are always other systems involved in the child's life: their family, childcare and/or school, physician, and often other service providers as well. These services should be integrated and/or coordinated in a System of Care for the child and family. Each agency/system will be responsible to fulfill its own legal and contractual obligations, but should at the same time focus on contributing to a seamless and coherent plan of care that addresses the identified needs of the child and family. To accomplish this:

1. Develop **case management** as a standard of care to serve the majority of MH needs.
    a. Promote case management as the point of responsibility within the mental health system to coordinate with the child and family's system of care, assure services in plan of care are delivered, and assure there is no break in services.
    b. Focus case management especially on high-needs children: e.g. who are at risk of residential or hospital placement, are in foster care; are receiving services from juvenile justice or multiple systems; or have no family or a non-participating or non-compliant family.
    c. Develop a way to coordinate and manage the points where kids cross systems, such as discharge planning from residential care, or entry into foster care.
    d. Develop procedures with system of care partners for designating a primary case manager when more than one agency is involved.
    e. Provide training for providers on case management.
2. Clarify and integrate County and provider **direct service roles**.
    a. Provide pre-diagnosis prevention, outreach and early intervention through a public health model, using County general fund.
    b. Provide intensive community support as a safety net to assure service delivery to children and families, when needed.
    c. Clarify service priorities and responsibilities for multiple partners in the child and family system of care, including: County mental health; metal health providers; other County programs; State Mental Health, Developmental Disabilities, and Department of Human Services (DHS), community services, schools, and County funded services at schools.
    d. Encourage public/ private partnerships.
3. Promote **involvement of other involved agencies/individuals** in developing a unified plan and participation in the system of care.
4. Improve **support for foster families**, and services for children in Foster Care.
    a. Provide a comprehensive assessment and care plan for children in foster care within the timeline of the legally responsible agency.
    b. Provide training for foster families on supporting young children with mental health needs, including crisis prevention, intervention, and specialized parenting skills.
    c. Expand availability of respite care to foster families.
    d. Work as a partner to support and develop capable foster care providers.

F. System of Care Clinical Development

1. Identify evidence-based **best practices**, and realign treatment practice and funding across the system of care.

a. Learn what works from research, best practices, and pilot projects; translate this into policy and systems development for the population.
b. Promote universal training and experience in developmentally appropriate assessment and intervention for professionals serving children.
c. Use training, advocacy and quality management to inform and motivate practitioners.
d. Work with providers to develop outcomes-based measurements.
e. Promote universal training and experience in wrap-around philosophy and service provision for all care providers in child and family serving systems.

2. Develop the **mental health work force.**
    a. Collaborate with providers, the State and local schools and universities to increase the number of qualified multi-lingual, multi-cultural professional staff working in the community.
    b. Provide cross training in increase knowledge throughout the system of care.
3. Develop a **culturally specific** and linguistically appropriate service system.
    a. Provide support to develop culturally specific and linguistically appropriate services.
    b. Coordinate services between culturally specific/culturally competent providers and other systems for the child and family's benefit.

G. Collaboration

County leadership should focus on collaboration with the multiple partners involved in the system of care for children and families.

1. **Collaborate with others** to further develop the system of care for children and families.
    a. Work across county departments and with other governmental and private child-serving agencies, with a goal of expanding combined efforts for young children, school-age children and adolescents/young adults.
    b. Adopt a stronger collaborative role in coordinating services funded by others, e.g. Intensive Treatment Services (ITS) Pilot Project and Psychiatric Day Treatment.
    c. Increase coordination between mental health and academic partners, such as schools and the Educational Service Districts (ESD).
    d. Expand **collaborations to pool and manage funding**, assuring clear and approved intergovernmental agreements among funders (which could include the county, state, schools, foundations, etc.) which:
        1. Achieve mutual benefits from the project,
        2. Specify the scope and funding for the project,
        3. Delegate specific decision making authority, and
        4. Provide clear termination procedures and conditions.

2. Create policies to **encourage blending, braiding, leveraging and/or pooling funds** across departments and with other government ands community agencies.
    a. Involve: government and private funders, business, partners, foundations, State Mental Health and Child Welfare, juvenile justice, education/schools, private insurers, primary care/public health, and youth addictions services partners.

b. Explore ways to maximize flexibility and continuity, without adding bureaucracy or costs.

3. Push a **political and public relations agenda** in support of healthy child development as the critical link to society-wide benefits of competent, caring and connected future citizens.

H. Funding

Funding for mental health services in the near term is expected to be limited to current funding levels. Funding strategies should focus on accountability for funds spent, and maintaining or increasing funds for underserved groups, including children.

1. Accurately **account for revenues and expenditures** for mental health services for children, including Oregon Health Plan and other state and county funds.
2. **Maintain and increase the proportion of children's Oregon Health Plan dollars** that are spent on child and family services.
3. **Reallocate existing resources** and **seek additional funding** as possible.
    a. Reprioritize use of funds to achieve top priority outcomes.
    b. Seek additional or new sources of funding, including funding collaborations, to support improved outcomes.
4. Develop a system to **coordinate benefits** with **physical health,** and **alcohol and drug** treatment services.
5. Prioritize savings from system redesign into **building capacity and expanding services** in the children's mental health system.
6. **Funding policies and mechanisms** should:
    a. Support the System of Care Values and Principles.
    b. Be invisible to the child and family.
    c. Prevent any further erosion of funding for children's services.
    d. Build children's services to the proportionate share of revenues as a floor.
    e. Invest savings from the adult system in children and youth services to build prevention and early intervention, not limiting total funding to the "floor".

I. Quality Management

A system of managing quality is especially important when transferring flexibility and risk to the provider system. To assure quality services are delivered:

1. Develop measures/means to assure that providers reach the desired outcomes over the multi-year plan, and measure progress and movement toward these goals.
2. Realign provider expectations through quality management, learning from model cases, training and technical assistance; develop a collaborative model for problem solving.
3. Provide monitoring, and utilize enforcement where needed.
4. Use outcome measurements that are valid, reliable, age/developmentally appropriate, and efficient/low cost.

J. System Structure

1. Adopt a **unified Mental Health Plan**.
    a. Establish a clear vision and a unified plan, including the needs of children and families; involve others to agree or amend the plan, and move forward.

2. Establish a **Child and Family System of Care Manager** position to coordinate and advocate for children and their families, and to spearhead action to implement the plan.
3. Increase **family involvement** in system development and design.
    a. Reform CAMHSA membership to include more youth, parents and community members; develop the ability of the group to serve as lead advocate for children's mental health.
    b. Seek input from families on the design of services.
4. **Contracts applied to children's services** shall incorporate:
    a. System of Care Values and Principles adopted by Board of Commissioners.
    b. Require Primary Providers to meet Cultural Competency requirements.
    c. Incentives for individualized, community-based services that meet the treatment needs of children and their families.
    d. Incentives for flexible services, non-traditional services, culturally specific services, case management, and intensive services, such as care coordination, respite care and in-home support services.
    e. Accountability to serve traditionally underserved children: ethnic, linguistic and other minority children; young children; juveniles and young adults; and so-called "non-compliant" youth.
    f. Incentives for collaboration with involved agencies, including childcare and schools, primary health, alcohol and drug providers, State Department of Human Services and Oregon Youth Authority, Juvenile Justice, Developmental Disabilities, and other community providers.
    g. Incentives to serve, and accountability for, high-needs children.
    h. Performance and outcome measures, implementation, and program evaluation, that support the System of Care Values and Principles, specifically including: respect for families, family involvement and empowerment, least restrictive/clinically appropriate services, coordinated/integrated services, culturally competent services, and timely access to appropriate services.
    i. Encouragement to include family members and a diverse section of the community on their governing boards and committees.

K. Training

In order to help family members, providers, child-serving agencies, and other professionals such as primary care providers and teachers work collaboratively toward a child-centered, family-focused system of effective community-based mental health services, develop and provide education and training on the following topics:

1. The mental health system, community resources, wrap-around services, and how to access these;
2. Family involvement, and child-centered/family-focused service delivery;
3. Normal child development, and emotional and behavioral disorders;
4. Effective parenting/teaching/intervention strategies for children with mental health disorders;
5. Coordinating a child's care;
6. Legal rights and responsibilities and grievance procedures;
7. Level of care determination, evidence-based best practices, and unified plans of care;
8. Evaluative tools and measures.

IV. Early Childhood Recommendations

Recent insights from brain research, along with long-term studies on early childhood care and education, stress the critical importance of good early childhood experiences in the development of healthy mental and emotional functioning throughout life.

To promote healthy development of children, national early childhood mental health experts recommend strategies that: promote the emotional and behavioral well being of young children; address barriers faced by families; expand the competencies of caregivers; and ensure children and families have access to needed services and supports.

Guiding principles for best practices in an early childhood system of care include:

- Strengths-based assessment and services;
- Individualized service delivery;
- Recognition of a family's rights and the resiliency of family systems;
- Family-centered, culturally-sensitive, community-based, coordinated services;
- Service delivery which evolves from current and emerging literature and research;
- Knowledgeable, skilled professionals who choose evidence-based interventions;
- Timing, frequency, duration and intensity of services matched to child and family needs;
- Continuous quality improvement through evaluation of strategies, utilizing outcome measures, and peer review as a quality assurance check.

Young children do have mental health needs. Recent research documents that prevalence rates for mental health issues for young children are identical to rates for children over five: 21% of young children meet the criteria for a psychiatric disorder, and 9.1% for a severe disorder.

Therefore, young children need the same quantity and quality of mental health services and supports those older children and adults require. These services must be delivered in the most natural environment possible, and involve all adults in the child's life. All young child-serving disciplines and organizations must work collaboratively to identify and serve the child and family in a coordinated, timely and effective way. Some children, because of the severity and/or complexity of their needs, will require more intensive levels of care.

For young children (under age 6), the following principles developed by Jane Knitzer, Ed.D., are recognized as a foundation for service delivery and system development.

Ten principles for an Early Childhood Mental Health Service System

1. A family-centered early childhood mental health service system, including mental health and related services, should be designed to support parents of young children to nurture and build caring relationships with them.
2. A family-centered early childhood mental health service system, including mental health and related services, should be designed to support non-parental caregivers of young children to nurture and build caring relationships with them.
3. A family-centered early childhood mental health service system, including mental health and related services, should be delivered, to the greatest extent possible, in natural settings, including homes, child care, health care, and family support settings.
4. A family-centered early childhood mental health service system should be designed to respect developmental processes as well as be flexible and individualized to meet the needs of young children.

5. A family-centered early childhood mental health and related service system should be sensitive to cultural, community and ethnic values of families.
6. Caregivers, home visitors, family workers, and administrators working with infants, toddlers, and preschoolers should have access to clinical services, case consultation and clinical supervision to strengthen their competencies in promoting emotional development in all young children, in young children who are at high risk for developing diagnosable problems, and in young children with already diagnosed problems.
7. Family service workers, home visitors and others working with families of infants, toddlers, and preschoolers and their families (including kinship and other foster parents, grandparents, and non-custodial fathers), should have access to mental health program consultation, case consultation and back up support for families requiring more intensive interventions, particularly if there are issues of substance abuse, domestic violence, child maltreatment, depression, and other mental illness.
8. Caregivers, home visitors, family workers, and administrators working with families of infants, toddlers, and preschoolers should have access to clinical supervision and support in dealing with such staff issues as burnout, cultural, and work place conflicts.
9. Young children, families, and programs experiencing crises related to violence, community disasters or family specific crises should have immediate and as-necessary access to crisis intervention and support.
10. Developing a family- and caregiver-centered early childhood mental health service system requires building partnerships among both primary and secondary support services at the community- and state-levels.

Early Childhood Recommendations:

Recommendations specifically for early childhood are based on the belief that that service to young children means service *through* parents and other caregivers. Appropriate service strengthens the family and achieves an optimal level of development for the child.

1. Expand or prioritize services to **high-risk groups**.
    a. Adult mental health system should offer no-waiting treatment to new parents with mental health issues, including to mothers identified through Oregon Children's Plan pre-natal and at-birth assessments.
    b. Expand services to offer mental health service in all Head Start and childcare locations.
2. Improve **outreach** to parents and children.
    a. Integrate physical and mental health care – make sure there is mental health screening at well-baby visits.
    b. Provide assessment and treatment at: Early Head Start/Head Start, Childcare settings, Foster Care homes, and Early Intervention/Early Childhood Special Education.
    c. Prioritize "child find" in high-risk adult populations (e.g. adults with mental health or substance abuse problems, or depression; who are cognitively impaired, incarcerated, or on probation or parole; who are involved with animal control violations, or domestic violence services).
3. Improve the **appropriateness and universality of mental health assessment** for young children.
    a. Adopt the "DC-0-3" as a diagnostic classification system for children 0-3 years of age (from Zero to Three's National Center for Clinical Infant Programs).

b. Promote mental health screening for infant's birth to school age as a part of regular health care.
c. Provide universal access to specialized and comprehensive mental health assessment for children birth to school age, as referred from health, childcare and early education systems.

4. Expand the **continuum of services** for young children.
   a. Expand therapeutic childcare; expand hours to better meet full day needs of working parents.
   b. Provide appropriate levels of day treatment within a seamless community-based system of care.
   c. Develop blended services for young children who have both mental health issues and developmental delays.
   d. Increase intensive in-home services to assist families of young children with high needs.
   e. Advocate for mental health services to be delivered where young children are, including within families, in childcare settings, and in conjunction with well-baby and well-child health visits.
5. Improve **coordination of services** for young children.
   a. Coordinate and advocate with physicians, including pediatricians, family practitioners and child psychiatrists.
   b. Coordinate services with the adult mental health and addictions system, when parents or other family members receive services.
6. Improve **training** for people involved in the lives of young children.
   a. Provide multi-disciplinary training to childcare providers and educators on promoting healthy social and emotional development, identifying children and families with mental health issues, and supporting young children with mental health disturbances.
7. Enhance **financing** for mental health services for young children.
   a. Coordinate benefits for young children with mental health disturbances.
   b. Promote parity of funding for mental health services in early childhood.
   c. Evaluate cost-effectiveness of services using best practices and performance measures.
   d. Advocate for funding through Oregon Health Plan and other health plans for services, based on "DC 0-3" diagnostic categories.

V. Recommendations for School-Age Children

The majority of children age 5 to 18 (and up to 21) are in school a large part of the day. In addition to their families, schools become a critically important part of children's lives.

Recent recommendations from the Surgeon General suggest tapping public schools to identify children with mental health issues, and improving service to racial and ethnic minority groups by locating services where adolescents spend time, i.e., schools. Schools have a special opportunity to identify children's issues because of the natural dynamics that occur between children and their peers and teachers, and children's responsiveness throughout the day.

Therefore mental health services for children should be provided in, or in coordination with, schools. There should be increased partnerships between schools, the County and providers to

provide appropriate screening, assessment and treatment. Training should be provided for school employees on: recognizing mental health issues; the impact on children, families and schools; responding to crisis; working with families and teams; and participating in a child's plan of care.

Parents of school age children should be full partners in developing the treatment plan or plan of care. Services must be appropriate for the child and family's language, culture, community and values. Coordination with other involved partners is also essential.

For children who have mental, emotional or behavioral disorders that qualify for special education services under an Individualized Education Program (IEP), schools, mental health providers and other involved systems should formally coordinate services with one another and with the child's family.

Recommendations for School-Age Children

1. Improve outreach, screening and **assessment** for children and youth.
    a. Promote use of a common framework for making decisions on level of care in the treatment of children and adolescents age 6 to 18.
    b. Implement screening for all school age children upon entering school to promote early identification of mental health concerns or disorders.
    c. Provide information, screening, assessment and referral in schools.
    d. Provide case management/ coordination of services among the family, providers, schools, and other services.
2. Expand and strengthen the **continuum of services.**
    a. Improve definitions of outcomes for day treatment services for children.
    b. Develop community-based intensive services as an alternative to high-cost residential treatment.
    c. Support services that improve school attendance, academic achievement and positive student behaviors.
    d. Support culturally and developmentally appropriate school-based services to emphasize: early identification; ease of access; case management; integration of physical health/ mental health/alcohol and drug services; family involvement and choice; individualizes and flexible services; and ongoing treatment and follow-up.
    e. Provide appropriate levels of service in integrated therapeutic and educational settings, such as therapeutic day schools or day supported classrooms.
3. Seek ways to replace funding and/or service capacity of **expiring grants:**
    a. Safe Schools grant ($2.75 M); and
    b. Center for Substance Abuse Targeted Capacity Enhancement ($750,000).
4. Improve **financing for high-need children** following residential placement.
    a. Initiate planning with the State to look at children returning to the community following State-paid residential treatment; look at ways for funding to follow the child, or other ways to improve continuity and outcomes.
5. Develop a **coordinated system for mental health services throughout the schools**, building on the success of current highly effective programs.
6. Improve **long-range system-wide planning** between schools and the County.

VI. Recommendations for Special Youth Populations

The Child and Family System of Care Workgroup recognizes that some children, especially older teens, have special needs, and may not be living with their families or attending school. Teens may have unique issues and cultures that need to be addressed to provide accessible, quality and effective mental health services. Such issues include:

Teen years are the time when many serious and persistent mental health issues emerge (schizophrenia, bi-polar, major depression), and are **also the greatest time for suicide attempts and suicide** to occur. Oregon's rate of suicide attempts for teens increased 5% in 2000; 76% of teen suicide attempts are by girls, and the highest rate of suicides is among sexual minority youth.

Girls may face different challenges than boys. Data shows that the pressures and pathways to self-destructive behaviors, as well as crime, are often different for girls than for boys. Girls' issues are more often internal (eating disorders, depression, substance abuse to mask pain of sexual abuse, running away, suicide attempts), whereas boys tend to externalize their issues, bringing them to the attention of Child Welfare and Juvenile Justice in greater numbers.

Many teens are not eligible for the Oregon Health Plan and therefore have limited access to mental health services. Even for pregnant and parenting teens, enrollment is very limited. Services are needed for teens who do not have insurance, or access to services through schools.

It is a challenge for providers to reach and engage at-risk teens. Teens may lack a strong support system, be parenting themselves, or be victims of violence, addiction or abuse. Too often, mental health services don't find teens who need services until there is a serious crisis.

Services need to be developed that respond to teen's developmental, gender, sexual identity and cultural needs. There frequently is a small "window of opportunity" to get a teen to go to counseling, and an immediate response needs to be available. Teens also need time to develop trust and relationships, but currently therapy is too often designed around structured office visits, which may not feel safe or comfortable for a teen.

Transition to adult services typically occurs at age 18, regardless of the youth's emotional maturity. This is a difficult time for families, who are losing legal authority over their child and are not always part of the adult treatment team. Transition for the teen and family should be planned for and supported, sensitive to the teen's emotional and behavioral needs.

State Committed Youth. A 1999 study showed that 19% of youth committed to the Oregon Youth Correctional Facility might have avoided commitment with appropriate services. Youth were typically: Anglo males, 15 years old, not enrolled in school, a history of problems with school, and with prior dependency referrals. Resources needed were: drug and alcohol secure treatment, mental health placements, culturally appropriate services, and long-term sex-offender treatment. Ease of access (such as no-waiting appointments) and specialized services are needed for this population.

Recommendations for Special Youth Populations:

1. Improve **access for youth**.
    a. Develop a youth, child and family-centered walk-in clinic at least during "after school/after work" hours, which feels safe for families, has experienced child and family-oriented staff (including expertise in children's medications), and ability to follow-through with the family and child, or teen.

b. Respond immediately to requests for service for youth; there may be a limited window of opportunity and kids often can't wait.
c. Assure that there is no artificial limit on the number of visits a teen may need.
d. Recognize that teens sometimes lack consistent family or even foster family involvement, or other natural supports.

2. Improve **continuum of services for youth.**
   a. Develop sub-acute care and other alternatives to hospitalization for adolescents in the community.
   b. Develop a secure adolescent assessment center; avoid use of arrest or admission to emergency room to obtain a needed assessment or services.
   c. Educate schools and the public on how to deal with acting-out behavior of youth, rather than referring to the criminal system.
   d. Develop vocational programs as alternatives for youth.
3. Improve services for **homeless youth**.
   a. Assure there is no waiting list for services for homeless youth.
   b. Promote access to mental health services at homeless youth service locations.
   c. Promote building trust between the youth and provider.
   d. Promote ease of access by minimizing paperwork.
   e. Train homeless youth providers on County mental health changes and opportunities for their youth.
4. Provide mental health and addictions services to address the needs and interests of **sexual minority youth.**
   a. Develop practical approaches to meeting these needs within school-linked and provider services.
   b. Advocate with private mental health providers to recognize and support the special needs of sexual minority youth.
   c. Provide training to educators on the special needs of sexual minority youth,
   d. Adapt services to the needs of trauma and abuse survivors within this group.
5. Increase **services for girls,** especially trauma and abuse survivors, who are currently underserved within the mental health system.
6. Improve services for **youth also involved with the Juvenile Justice system.**
   a. Develop blended/braided funding to pick up costs for continued mental health services when youth go into detention (and Medicaid funds end), and when they come out of detention.
   b. Improve providers' ability to address youth delinquency, and alcohol and drug problems, concurrently with mental health issues.
   c. Ensure appropriate mental health services are available to youth being held in the County jail (e.g. due to Measure 11).
   d. Provide on-site dual-diagnosis assessment for youth in the Juvenile Justice system, along with case management.
   e. Integrate addiction and mental health services to serve dual diagnosis youth who are in the Juvenile Justice system.
   f. Prioritize mental health services for youth and families in the Juvenile Justice system who have potential to harm themselves and public.
   g. Resolve confidentiality issues to improve continuity of services for juvenile justice-involved youth.

7. Improve the process of **transition to the adult system.**
    a. Involve both youth and parents in transition planning.
    b. Work with schools to develop a uniform approach to transition to adult services, including development of Individual Transition Plans (ITP).
    c. Provide assistance to parents and youth in applying for with Supplemental Security Income (SSI), Oregon Health Plan and Disability Services.
8. Improve access to and availability of **wrap-around services,** including:
    a. Career development;
    b. Housing;
    c. Independent living skills;
    d. Ongoing education.

VII. Recommendations for Quality Assurance Measures

The child and family system of care is distinct from adult service systems and it is still evolving; thus, there is a need for targeted process and performance measures that are specific to the adopted System of Care Values. As the child and family system of care develops, so should its quality management program.

Accountability for the children's system of care will be driven by performance and outcome measures. Outcomes related to System of Care Values should be one factor used in contracting for child mental health services with community providers. They will also be used to assess the overall functioning of the system of care in Multnomah County.

To start with, the Performance Measurements Committee has identified five key areas to measure, which reflect the adopted System of Care Values. The group also recommends that the County's Quality Management Committee form a subcommittee to continue to address and monitor issues related to child and family mental health. Children and family members shall have a central role in evaluating and monitoring the quality of children's mental health services and in determining future areas for measurement. In addition to children and families, the subcommittee should include other children's system stakeholders who may not be members of the larger Quality Management committee, and the subcommittee should also utilize technical assistance from experts in the evaluation of children's systems of care.

The five key areas identified by the performance measures committee are:

AREA 1: Access

GOAL: Children and Families will have timely access to appropriate mental health services

- Children and families will have timely access to a mental health assessment
- Services to children and families will be initiated in a timely manner following the initial assessment

AREA 2: Service Integration

GOAL: Children and families receive services that are integrated, with linkages between child-serving agencies and programs

- For children who have high levels of need that cross multiple child-serving systems, services will be coordinated.

AREA 3: Level of Restrictiveness

GOAL: Children will receive services in the least restrictive, most normative environment that is clinically appropriate

- The level of restrictiveness of both a child's living environment and school placement will stay the same or improve over the course of services
- Children are in the least restrictive educational and living settings that are clinically appropriate.

AREA 4: Cultural Competence

GOAL: Services meet the needs of children and families from diverse ethnic and cultural backgrounds

- Children and youth from diverse ethnic and cultural backgrounds will have equal access to assessment and services
- The cultural and ethnic demographics of children receiving mental health services should be consistent with the demographics of children who are enrolled in the Oregon Health Plan.
- Measures in Areas 1, 2, 3 and 5 will be analyzed for differences by race, ethnicity and language.

AREA 5: Family Involvement

GOAL: Families are full participants in all aspects of the planning and delivery of services

- Families will be involved in the planning and delivery of services for their children.
- Families will be satisfied with the quality and effectiveness of services.
- Family members will be actively and fully involved in decision-making bodies.

AREA 6: Functional Status

GOAL: Children and families improve functionally. Specific goals would be developed by the QM Committee, but would include measures such as:

- Number of days of school attended per year;
- Graduation rates from middle and high school;
- Number of days in detention/incarceration per year;
- Number of child abuse reports,
- Number of days per year spent in hospital or residential settings, as a ratio over days in all services

Mechanisms for monitoring these key areas include family surveys, chart reviews and outcomes measures. All reports to the QM committee should be broken down by age, race/ethnicity and language categories. Multnomah County should continue to improve quality management and refine performance measures.

#

cfsocreport.final.01/29/02

Child and Family System of Care Workgroup

List of Members

Chair: Multnomah County Commissioner Lisa Naito

Assistant Chair: Mark McKechnie Juvenile Rights Project

Committee Members:

Rob Abrams	Department of Community Services/ Children's Mental Health Partnership
Linda Castillo	DCFS/Cultural Competency Committee
Phil Cox	Oregon Youth Authority
Peter Davidson, MD	DCFS/ Mental Health and Addictions Services
Karen Gorton	Early Childhood Care and Education Council
Vern Hoffer	Portland Public Schools
Mary Lou Johnson	Centennial Public Schools
Larry Marx, MD	DCFS/ Mental Health and Addictions Services
Carole Romm	CareOregon
Ralph Summers	State Mental Health
Kathy Turner	Commission on Children Families and Community
David Willis, MD,	Northwest Early Childhood Institute

Parents:

Sandy Bumpus	CAMHSA/National Alliance for the Mentally Ill
Angela Steckly	Mental Health and Addictions Services, Family Involvement Coordinator
Mary Jo Thomas	Foster Parent
Cheri Waller	Foster Parent

Provider Panel:

Gene Borkan, MD	Providence
Bruce Baker	Morrison Center
Norwood Knight-Richardson, MD	Legacy
Jackie Mercer	Native American Recovery Association/Cultural Competency Committee
Derenda Schubert,PhD	Trillium
Ginny Robinson	Mt. Hood Mental Health
Holden Leung	Chinese Service Center/Cultural Competency Committee

Multnomah County Staff Resources:

Tom Wirshup	DCFS/ Mental Health and Addictions Services
Rich Scott	Department of Community Justice
Consuelo Saragoza	Health Department
Nancy Middlebrook	DCFS/ Mental Health and Addictions Services, Addictions Program
Vernon Baker	DCFS/ Developmental Disabilities
Mary Shortall (and/or Jeanne Wheaton)	Aging and Disability Services
Stephen Young	DCFS/ Mental Health and Addictions Services

#