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An Analysis of the Current United States and State of Washington's Mental Health Policies Serving Children and Families

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Abstract

An Analysis of the Current United States Federal and State of Washington's Mental

Health Policies Serving Children and Families

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Due to continued fragmentation and gaps in mental health services and the

increase in the prevalence of mental health problems for children, youth, and their

families, these populations remain underserved. In 2003, the federal New Freedom

Commission (Commission) responded by publishing policies to address these concerns.

As directed in 2005, the Substance Abuse and Mental Health Services Administration

(SAMHSA) funded planning incentive grants to states to transform their delivery of care.

The study reviewed the federal policy, specifically the recommendations of the

Commission's Subcommittee on Children and Families, and Washington State's policy

and implementation actions of its five-year SAMHSA incentive grant. The method

included searching, reviewing, and analyzing the literature on the topic published since

approximately 2002. The analysis distilled the recommended determinants in children's

mental health care transformation: prevention, early intervention, and screening in child

welfare (juvenile justice and foster care) strategies; evidence-based practices; geographic

disparities; workforce barriers; cultural competence aspirations; and consumer, school-

based mental health, and primary care providers' role expectations.

Despite innumerable studies, policies and services remain fragmented with gaps.

The following topics from the outcome data require continuing attention: increasing the

cultural competency of professional services that are efficacious, and designing and promulgating measures for evidence-based practice specific to children.

Three themes emerged regarding how to serve children's mental health needs in Washington State in a more efficacious manner. Within the penumbras of cultural competency and outcome-based measures, constructs for evidence-based practice for children need to be age-developmentally appropriate. Simultaneously, both the family role and venues of service delivery need to be considered, e.g., schools, out-of-home placement, and clinics. Access to mental health care through schools and primary care providers needs to be collaborative with behavioral health professionals. School policy needs to link students' attendance and achievement with their physical and behavioral health. Training for the mental health workforce requires increased cultural competency. Rural mental health care requires incentives to train and retain a workforce reflective of the demographics, particularly in the areas populated by persons of color. Also, the number of prescribers needs to increase through certification of nurse practitioners and psychologists.

The electronic version of this dissertation is at Ohio Link ETD Center, www.ohiolink.edu/etd.

Dedication

With a warm heart, I dedicate this dissertation to my parents, Cyril Frederick

Huvar and Doris Evans Huvar, who taught me love, courage, and joy toward the world.

Acknowledgments

Mahalo to my family for their generosity, patience, and support that have made it possible to produce this document. The wealth of knowledge and experience given by my advisors, professors, cohorts, and clients has opened up new paths that I never knew existed. All of this support has been a gift that I cherish as I continue my journey into the field of psychology with its rich past and open future. Aloha no.

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An Analysis of the Current United States Federal and State of Washington's Mental

Health Policies Serving Children and Families

Chapter 1

Mental health policy often remains enigmatic to many professionals in the field of psychology. Little awareness exists among psychologists about the protocols and politics regarding these policies, their real and potential impacts to clients, as well as the availability of resources for their clients from these efforts. Nonetheless, the mental health policy of this nation profoundly impacts the profession and its ability to provide essential and adequate services for its clients from childhood and reaching into adulthood, as noted in the following letter.

In her letter to the New Freedom Commission (Azrin, Moran, & Myers, 2003), a mother highlighted the problems faced by her family in its history of mental care of her son. This mother told of the tragedy of her son who had suffered with paranoid schizophrenia since his elementary years but was not diagnosed until the age of 17. With little coverage provided by the family's private insurance and after exhausting their income, this mom quit her job to qualify for Medicaid. During one of his psychotic episodes, the family called the police, but her son stabbed an officer. The young man awaited trial in jail, and, while incarcerated, he suffered from his illness and trauma. After being convicted of assaulting the officer, he then served ten years in jail. The family felt the stigma of the criminal justice system and public ignorance about mental illness, and the mother worried about his homecoming when paroled. His symptoms had become worse with limited mental health care in prison. After his release, he also would be ineligible for many programs, due to his conviction as a violent criminal. The family

had no financial resources to care for their son's mental health or housing, and no support for him appeared to exist in the system. She stated that she could not care for both her husband with his frail health and her son in his grave situation.

The story exemplifies the array of issues and concerns expressed and faced by parents and children. This dissertation reviews the United States' mental health system policy as proposed by the Commission and its application to the current trends and needs of children, adolescents, and their families in the State of Washington. The scope of the dissertation is limited to a review of published government documents and scholarly literature that have examined the current trends in mental health policy.

A myriad of efforts address children's mental health within the federal government. For example, youth with serious mental health conditions transitioning to adulthood can have their needs addressed by 57 federal programs directed through 20 or more agencies within six departments in federal government (Bazelon Center for Mental Health Law, 2005). In its needs assessment for its planning effort, Washington State solicited data from 17 state entities connected with mental health and recovery services (Kohlenberg, Bruns, Willey, McBride, Allard, et al., 2006).

Chapter 2—Methods

Research found in the document includes legislation, laws, professional journals, books, reports, and other materials on the topic. Due to the timeliness of the overall topic, the research continued until the final submission of the draft to the dissertation committee. More than 50 journal articles about children's mental health care were identified. The search generally sought information written from 2002 to present to augment the reports produced by the Commission (2003a, 2003b). This demarcation was

based on the assumption that the Commission and its subcommittees would have not had an opportunity to have reviewed materials in press during the year before their deliberations and prior to the release of the Commission's final report in April 2003.

The majority of data were retrieved from various web sources, including Ohio Link and EBSCO Publishing. Specific information and data were also retrieved from sites hosted by various federal and state agencies and programs. They included the United States Department of Education, United States Department of Health and Human Services, United States Substance Abuse and Mental Health Services Administration, United States Department of Justice, American Psychological Association, American Psychiatry Association, Federal Congressional and Washington State Legislative proceedings, Washington State Department of Social and Health Services, Washington State Mental Health Transformation Working Group, and Google, as appropriate.

The search included the following terms, often in combinations with the germane topics and subjects: New Freedom Commission, Community Mental Health Act, Transformation Act, Washington State Transformation Act, mental health policy, transforming mental health law, mental health policy plus a topic, e.g., Medicaid, children, early intervention, mental health, primary care provider, juvenile justice, foster care, and so on. Other terms searched included Washington State, teen, adolescent, youth, toddler, infant, history, cultural competency, workforce, evidence-based practice, regional support networks, State Children's Health Insurance, Apple Healthy for Kids, prevalence, schools, determinant, gaps, diversity, rural, fragmentation, gaps, and help seeking. The searches included appropriate combinations of the words and applicable acronyms.

The document generally referenced the studied populations using the term *children* to include all persons under the age of 19. When the literature specified a specific age that needed distinction, labeling identified the population, e.g., infant, baby, toddler, adolescent, or teen.

The use of the term *persons* or *people of color* referenced multiracial and biracial persons. It also included Latinos and Hispanics, African Americans, Asians and Asian Americans, Native Americans, Alaskan Natives, Native Hawaiians, and Pacific Islanders. These generally mirrored the categories used by the U.S. Census Bureau (2001).

Chapter 3—Prevalence and Need

In the United States, children and youth have an "alarmingly high prevalence" of mental health problems (Huang, Stroul, Friedman, Mrazek, Friesen, et al., 2005, p. 615; Huang served as the co-chair of the Commission's Committee on Children and Families; U. S. Surgeon General, 1999). The Commission's Subcommittee on Children and Families (2003) concluded that we have a "public health crisis." Estimates are that 20% of the nation's children have a mental disorder, and 10% of youths have a serious emotional or behavioral disorder that results in a functional impairment at home, in school, or in their communities. Only 20% of children who need services receive mental health care, and 9 to 13% of youth who need substance abuse treatment receive it (Cooper, 2008). Suicide remains the third leading cause of death for youth from age 10 to 24 (U.S. Department of Health and Human Services, US DHHS, 2008b).

Of the 6 million residents, including 1.5 million children (0 to 18 years of age), in the State of Washington, 23.6% (356,124) have a diagnosable disorder under the DSM-IV-R (APA, 2000) that involves mood, thought, conduct, or anxiety. Additionally, 7.7%

of children (116.193) suffer both a diagnosable disorder and a disorder that limits life functioning (Costello, Messer, Bird, Cohen, & Reinherz, 1998).

The pervasive nature of the diagnoses for these children often results in poor academic achievement, high school dropouts, low job success, lack of independent living, greater health issues, and suicide (Subcommittee on Children and Families, 2003). The reported life-long chronic problems include greater conflicts in their intimate relationships, a higher probability of being fired from jobs, a greater likelihood of becoming a crime victim, and an increase in the prevalence of antisocial behaviors (Kendziora, 2004). The annual public cost per child for these behavioral issues ranges from $3,400 for elevated problems to $8,700 for diagnosis of conduct disorder; the cost per child during middle and high school is $23,996 for behavioral problems and exceeds $61,000 for conduct disorders (Foster, Jones, Bierman, & Coie, 2005). Furthermore, low-income children account for a disproportionate percentage of the population suffering with emotional problems. The parents of ethnic minority children "are less likely than other parents to seek assistance for their children…"(Marsh, 2002, p. 20). The Commission (2003a) concluded that the delivery of children's mental health services remains "fragmented" and "in disarray" (Mills, Stephan, Moore, Weist, Daly, et al., 2006).

The gap between knowledge and action has not been spanned. Specifically, the Commission's Subcommittee for Children and Families (2003) recognized the need to

- Reduce fragmentation in responsibilities and funding;
- Focus on prevention and early intervention;
- Understand the specific mental health problems for children and stigma;

- Fulfill unmet needs and disparities in access;

- Bridge the gap between current knowledge and current practice;

- Foster family support and partnerships;

- Identify gaps in services;

- Prepare a workforce to address the problems; and

- Garner accountability and quality improvements.

The subcommittee outlined a comprehensive approach to promote, preserve, and restore the mental health of children. However, little implementation of the plan has occurred. Perhaps the extension of knowledge to action has failed because little scientific study has noted how the Commission's work has affected implementation of policy. This major gap became apparent in the review of journal articles that addressed the same policy concerns for the topic areas addressed in the report. Specifically, a dearth of journal articles listed the new national policy measures or the implementation of the Commission's (2003) measures. A general lack of awareness existed about the work of the Commission and its recommendations (Mills et al., 2006). Few stakeholders have used the findings of the Commission to affect policy, research, or practice (Shelton, 2003).

The concerns expressed by Huang et al. (2005) are directly relevant to the State of Washington. In fact, national mental health policy can help fill the many gaps identified in the literature about how to address the needs of children and youth in the State of Washington.

History of public mental health policy for children.

Policy on child mental health issues remained below the radar on the national scene until the beginning of the 20th Century. President Taft signed the federal

Children's Bureau into existence in 1912, after 11 years of Congressional struggle. The agency was aimed at children's guidance and development: "…to investigate and report on infant mortality, birth rates, orphanages, juvenile courts, and other social issues of that time" (US DHHS, 2009a). From its inception, the Children's Bureau was plagued by potential rivals—the Department of Education, the Public Health Service, and pediatricians; they feared "...that the Bureau would encroach on their territory, and [with] one or two missteps [on the part of these older programs], and they would organize and lobby for its abolition" (Tichi, 2007). Efforts to address the welfare of this nation's children and youth have faltered since.

Nearly a century ago, the federal government also attempted to address the abandonment by families of *wayward* youth (Lourie & Hernandez, 2003). Specifically, court clinics were developed that served as the first mental health services to provide solutions less punitive than jail. No enduring policy ever emerged and the clinics that fostered this work disappeared.

In the post World War II years, a shift occurred from the states governing of mental health to the national government (Knitzer, 1982). In 1954, the National Advisory Mental Health Council issued a list of policy measures that changed the focus for mental health care from state efforts to a national government focus (Gorb, 1991; Knitzer, 1982). At that time, reform included federal funding for building hospitals and providing research money. Simultaneously, the biomedical lobby grew in prominence encouraging pharmacology for treatment in the medical and psychosocial sciences to promote mental health. In the national policy espoused more than fifty years ago, the National Advisory

Mental Health Council specifically addressed the needs of children in three of its nine recommendations, and they follow.

- The basis of prevention is correction of faulty child-rearing practices and the treatment of emotional disorders in childhood;

- Knowledge of the psychological development of the child by professionals and laity is the keystone of mental health; and

- Ministers, schoolteachers, recreational workers, and mental hygiene societies can stave off tendencies to mental disorder… (Gorb, 1991, p. 178).

Further national reform efforts guided specific mental health policy that resulted in several influential events during the 1960s. With the advent of Medicaid, indigent children became eligible by mandate for mental health care. In 1965, Congress established the Joint Commission on the Mental Health of Children, recognizing that a fraction of children received sufficient services to meet their mental health care (Lourie et al., 2003; Huang et al., 2005). The Joint Commission fostered the concept of child advocacy, continuing the principles of guidance by calling for the implementation of services through child welfare agencies.

In the early 1970s, Congress created the Community Mental Health Center Program that served as a major force in the recognition of children's special needs (Lourie et al., 2003). However, when their federal funding disappeared, states eliminated the services targeting the most vulnerable population—children. With its definition of a disability as a serious emotional disturbance, special education received recognition and a mandate to provide mental health services for this population in 1975. The All

Handicapped Children Act (currently, Individuals with Disabilities Education Act of 1990) focused on education with few mental health services.

In 1977, Jimmy Carter initiated a President's Commission on Mental Health (Gorb, 2005). In this effort, the policy focus shifted toward mental *health* and away from mental *illness,* using the public health model, i.e., taking into consideration the impacts of environment, social services, and prevention. Enlarging the definition to mental health placed the seriously mental ill in competition with other populations whose needs fit within the rubric of mental health. This divided community mental health into two underserved populations: chronically mental ill adults and children with serious emotional disturbances. Government response focused entirely on a small program titled "Most-In-Need"—services for American Indian and Alaskan Native children (Lourie et al., 2003). However, as its first priority, chosen from more than 100 recommendations, the President's Commission on Mental Health identified goals for the mental health of children—including prenatal, day care, and foster care to prevent future mental disabilities—as well as a recommendation to create a center for prevention (Grob, 2005).

Grob (2005, p. 451) summarized the history of the President's Commission on Mental Health and the problems it faced in mental health policy development and implementation that are relevant for children as follows:

- Bureaucratic rivalries within and between governments;
- Tensions and rivalries within the mental health professions;
- Identity- and interest-group politics;
- Difficulties of distinguishing the impacts of poverty, racism, elitism, stigmatization, and unemployment in the etiology of mental disorders; and

- An illusory faith in the ability to prevent mental disorders.

Although an executive initiative, the Mental Health System Act arose from the commission's work. With the change of administration in 1981, President Reagan rendered it moot through the passage of his Omnibus Budget Reconciliation Act (Gorb, 2005). This law diminished the direct role of federal government, which had been providing block grants to states for mental health services, and the budget was reduced by 20 to 25%.

Additional studies continued documenting the system's inadequacies in mental health for children, serving as a catalyst for change in the federal sector. Knitzer (1982) reviewed the work of the Children's Defense Fund study titled *Unclaimed Children* (Lourie et al., 2003) and described the mental public health policies at that time as a *mockery* of the concept of continuity of care for children. Knitzer noted serious concerns at the state level regarding the service and protection of the seriously mental ill children and youth. She found a lack of basics. These included a lack of assigned staff or data regarding available services, clear legislative mandates for mental health departments, and little advancement of early interventions for residential and outpatient services with the more restrictive level of care being fostered without proof of effectiveness for these populations. She also reported that seriously disturbed children remained unclaimed by all public systems responsible for them. They were excluded from schools, placed into foster care, and detained by juvenile justice agencies without access to mental health services.

In 1982, responding to Knitzer's report, the National Institute of Mental Health (NIMH) initiated the Child and Adolescent Service System Program (CASSP) intended

to aid states and communities in developing systems that targeted children identified with serious emotional disturbances (Lourie et al., 2003, Huang et al., 2003). This policy established the concept of *system of care* (SOC): children receive multiple services through mental health, special education, juvenile justice, and child welfare agencies. Its core values include community care, child-centered, family-focused, and culturally appropriate. To foster these values, services structures should be comprehensive, individualized to and partnered with the child and family (Lourie et al., 2003; Huang et al., 2003). This concept was the backbone of the Commission's (2003) mental health policy for children and their families.

In 1992, Congress supported the concept of system of care for children in its grant initiatives, Comprehensive Community Mental Health Services for Children and Their Families Program (Lourie et al., 2003; Huang et al., 2005). In 2005 its federal grant funding was approximately $100 million, disbursed to states, communities, territories, and tribal organizations.

Two major fiscal programs also increased services to children through federal and state partnership programs—Medicaid and State Children's Health Insurance Program (SCHIP). Both programs have provided health insurance for low-income and uninsured children, populations identified as underserved in mental health care and thus considered to be at more risk. Medicaid became available in 1965, with increasing levels of coverage over the years becoming available based on income eligibility and the age of children. The U.S. Congress established SCHIP in 1997.

In February 2009, President Obama signed the Children's Health Insurance Program (CHIP) Reauthorization Act, authorizing an increase in coverage and allowing

4.1 million additional uninsured children to receive benefits from 2009 to 2013

(Georgetown Center, 2009a). The law also allows states to cover benefits through school-

based health centers. Although the reauthorization legislation does not require mental

health services, states are required to provide mental health and substance abuse services

that have parity with medical and surgical benefits that can be fulfilled by the

implementation of "Early and Periodic Screening, Diagnosis, and Treatment" (EPSDT;

Georgetown Center for Children and Families, 2009a). See Chapter 3 herein for a

summary discussion regarding the current fiscal determinates in children's mental health

care.

An earlier catalyst toward mental health reform for children occurred in 1999.

The U.S. Surgeon General sponsored a conference on children's mental health. The

resulting policy reestablished mental health for children as a national priority and

outlined steps to address their needs in combination with their cultures and communities

(Huang et al., 2005; U.S. Public Health Service, 2000).

Three years later, guided by the Surgeon General's report, President Bush

initiated the current movement in federal policy reform to improve the mental health of

children. By executive order, the President called for a review of the nation's mental

health policy through the creation of the New Freedom Commission (Commission). The

directive tasked the Commission with the mission of identifying policies that the federal,

state, and local governments could implement "to recommend improvements to enable

adults with serious mental illness and children with serious emotional disturbances to

live, work, learn, and participate fully in their communities" (67 CFR 86, 2002, §3). The

Commission's chairperson, Dr. Hogan, stressed the need to support the recovery of a

missing element in federal policy governing mental health systems. He also noted that the program policies of the states remained attached to their block grants (Sills, 2003).

The national goals of the New Freedom Commission.

From its efforts in its final report entitled *Achieving the Promise: Transforming Mental Health Care in America* (US DHHS, 2008a; Commission, 2003), the Commission recommended transforming the nation's mental health policy by implementing six goals so that

1. Citizens understand that mental health is essential to overall health;

2. Mental health care is consumer and family driven;

3. Disparities in mental health services are eliminated;

4. Early mental health screening, assessment, and referral to services are common practice;

5. Excellent mental health care is delivered and research is accelerated; and

6. Technology is used to access mental health care and information.

American Psychological Association's position on transformation.

By invitation from the Commission, the American Psychology Association (APA, 2003) presented testimony. The APA stressed improvement in the areas of outcomes, treatment, access, systems of care, recovery, and stigma. The APA recognized that the federal government provides leadership and direct fiscal support for mental health programs. Its major recommendations included

1. Fostering the application of effective treatment and services;

2. Extending the opportunities for professional training;

3. Improving coordination among the providers of services; and

4. Increasing the ability of adults and children in need of services being integrated in the community (Marsh, 2002).

In response to the recommendations of the Commission, the APA testified at the Substance Abuse and Mental Health Services Administration (SAMHSA) regarding prioritizing actions for the national agenda. APA identified three recommendations that provided the most promise toward achieving a transformation of mental health care. Specifically, in order of priority, they are

- Align relevant federal programs to improve access and accountability;
- Improve and expand the workforce to provide evidence-based services and support; and
- Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports (Honaker, 2003, ¶ 4, 7, & 10).

Washington State's policies on children's mental health.

Historical documentation of Washington State's past policies governing mental health remains sparse. However, Washington adopted the Medicaid managed health care system in the 1980s. The state at that time created Regional Support Networks to administer its funds, and services were delivered regionally, in local communities, with the goal being integration and coordination (DMA Health Strategies, 2009).

Since the late 1980s, Regional Support Networks (RSNs) have engaged communities (DMA Health Strategies, 2009). Created by the legislature, the Regional Support Networks are tasked with administering state funds through a vision of delivery of "ambulatory delivery stems that would provide both improved quality of services and cost efficiencies...grounded in local services and in building 'community'...driven by a

system of strong local providers and county government" (p. 7). In 1993, the State began the delivery of Medicaid behavioral health care systems, including delivery to children and their families. Beginning in 1998, pursuant to the Washington's Community Mental Health Act (Community Mental Health Services Act, RCW 71.24, 1989), the state shifted managed mental health care systems to the Regional Support Networks in recognition that they have major responsibility over involuntary mental care and counties, and they oversee alcohol and drug treatment, people with developmental disabilities, and local criminal justice systems, including juvenile detention. Although recognition exists for the Regional Support Networks' fulfillment of some of their original goals, the need for coordination, integration, and seamless care has only been partially met, according to the study by DMA Health Strategies prepared for the Department of Social and Health Services, Health and Recovery Administration, Mental Health Division.

State of Washington's application of the Commission's recommendations.

In 2005, using the Commission's national policy that governs children's mental health, the federal government, through SAMHSA, the DSH solicited grants for a limited number of entities in fiscal year 2005 of approximately $18.8 million (a biennium budget) for projects that did not exceed a period of five years. The intent of the Mental Health Transformation State Incentive Grant Program was to be responsive to the recommendations of the Commission's final report (U S DHHS, 2008a*)*. The federal government awarded grants to seven states to initiate its national policy on mental health (US DHHS, 2005).

The Mental Health Transformation State Incentive Grant program, a SAMHSA's Infrastructure Grant, was intended to support infrastructure and service delivery

improvement activities, and to establish a solid base to deliver and sustain effective

mental health and its related services. More specifically, SAMHSA expected these

programs to foster both expanded and newer planning and development to promote

transformation to systems designed to foster recovery, while fulfilling consumer needs.

State grantees were encouraged in their applications to work toward creating mental

health planning and policy that would

- Increase the flexibility of resource use at the state and local levels by encouraging

  innovative uses of federal funding and flexibility in setting eligibility

  requirements;

- Increase accountability at the state and local levels of government that affects

  consumers and families; and

- Expand options and services for consumers and families.

In 2005, the governor created the Transformation Working Group to identify

actions intended to fulfill the Commission's goals. In its initial grant application, the

State of Washington submitted a package that fit within the state's directive toward its

vision of transformation of mental health. In its effort entitled *Partnerships for Recovery*

(Washington State Office of the Governor, 2005), the Washington State grant application

proposed addressing eight key elements:

1. Creating a social marketing initiative to reduce the stigma of mental illness,

   increasing awareness of mental health as an essential part of health, and

   promoting support for mentally ill individuals in the community and workplace;

2. Strengthening the state's infrastructure for consumer and family support and

   advocacy;

3. Developing a comprehensive approach to insure participation of consumers as service providers;

4. Reducing ethnic and geographic disparities and enhancing the cultural competence of all systems;

5. Adopting a strengths-based, consumer-driven care planning model in all state departments serving mentally ill individuals;

6. Implementing training and fiscal and regulatory incentives for the expanded use of evidence-based recovery focused practices;

7. Developing a web-based data infrastructure to support direct service, planning, and evaluation to form a basis for system-wide accountability to citizens and consumers; and

8. Developing a consumer-driven, formative, process, and outcome evaluation.

(WA Office of the Governor, 2005, p.1)

Specific to children, Washington's grant proposal identified more than ten actions to meet the goals that the Subcommittee for Children and Families (2003) had identified for early screening, assessment, and referral service for early childhood, as noted in Appendix A. In response to its application in the same year, the State of Washington received a pilot grant to initiate its Mental Health Transformation to implement recommendations identified by the Commission (US DHHS, 2008a). To keep the public abreast of its ongoing planning process, the State of Washington established a web site that provides background material, current activities, and interface tools enabling participation in the process (WA TWG, 2006).

Needs assessment and resources. In developing a transformation plan in response to the goals of the Commission (2003a), the Washington State Transformation Working Group (Kohlenberg et al., 2006) conducted an extensive needs assessment and resource inventory. It tapped the knowledge of stakeholders by using qualitative methods. Through interviews, surveys, and public hearings held throughout the state, the Transformation Working Group consulted nearly 800 mental health consumers and 44 executives and managers of 16 agencies and programs that provided state-funded services. The report produced the following findings about the needs of children and their families and recommended that services should do the following:

- Continue to identify children and families who lack access to services, such as at-risk children of adult consumers, [and those]..."who are troubled but do not have thought disorders" (p. 127);

- Seek the underserved who remain outside the system and possess identified problems;

- Encourage and provide incentives to providers who use evidence-based practices;

- Review outcomes for quality control of current services that exceed the expectations of the Juvenile Rehabilitation Act and Community Mental Health Initiative;

- Integrate DSHS-administered projects to adequately serve children and teens from prenatal, infancy;

- Launch early interventions through schools, foster care, and the juvenile justice system;

- Provide the consumers and their parents with a more direct voice about the implementation of programming rather than treat them as "adjunct consumers;"

- Develop greater cultural competency by defining mental health with evidence-based practices that have established norms applicable to people of various races and ethnicities;

- Mandate, expand, and fund early screening and referrals for mental health care in schools and primary care to enhance collaboration efforts.

- Expand the use of technological changes, particularly for health records and web access to expand access to communities; and

- Identify gaps in training for consumers. Provide information on how to access services to providers once referrals call for follow-up from mental health screening.

From its needs assessment, the Transformation Working Group identified and incorporated into its action plan 27 recommendations to transform the State of Washington's mental health system (WA TWG, 2006). As noted in Appendix B, at the request of the Governor, the Transformation Working Group voted and prioritized two tiers of recommendations. The grantor (US DHHS, n.d.) reviewed these priority recommendations and responded with few substantive comments to the state regarding fulfilling or complying with the intent of the Commission's goals to foster the transformation of mental health. All six outcomes addressed the concerns for the population of children. Tier I (one through three) and Tier II (four through six) recommendations, in order of priority, follow:

1. Increase system collaboration and service integration;

2. a) Create a proactive, rather than reactive, system that serves the entire family; and

    b) Provide additional services in the continuum, including respite, wraparound services, day treatment, and evidenced-based programs.

3. Revisit the Access to Care Standards by decreasing the number of families seeking Voluntary Placement Agreements for services in the Children's Administration due to mental illness. Increase mental health treatment and community supports for biological parents and their children to successfully return children to their homes after a dependency has been filed by DSHS;

3. Decrease the number of people with mental illness who are entering the criminal justice system;

4. Provide access to appropriate, quality treatment from trained providers to consumers;

5. Create seamless, wraparound care, including early identification, intervention, housing, benefits, and transition to adulthood for youth 13 to 24. Accomplish this by using evidence-based practices. Reduce stigma while enhancing recovery and resiliency; and

6. Fund services that foster recovery directly to consumers (WA TWG, 2006).

The complete picture of proposed mental health care policy for children includes the six additional recommendations developed and published by two subcommittees of the Transformation Working Group (2006). The Youth in Transition Subcommittee also recommended

1. Support for consumers' and family members' choices, tailored to their cultural, community and individual needs by using self-directed care, including sponsors, mentors, and guides, i.e., peer-to-peer support;

2. Reliable access to quality service and support; and

3. Use of consumers' and family members' feedback and involvement to review periodic quality improvement in all systems.

The Children, Youth, Parents and Family Subcommittee recommended:

4. Increase of state-only funds to reduce requirements for these funds and expansion of their use to fund parent organizations and mentorships so that those who are not in the country legally, non-Medicaid eligible children/youth and families, the working poor, and people who have exhausted their insurance benefits are better served;

5. Increase support for parent and youth organizations, support groups, peer support, and parent partners for any caregiver family, including foster, adoptive, and kinship families. Increase transparency of partnership involvement at all levels, including client-driven/directed services for youth and parents.

6. Provide training for parents/youth, professionals, and others, i.e., teachers, kinship care providers, and foster parents, to address cultural diversity beyond linguistics and ethnicity. Provide information on mental illness, strategies, and interventions in behavioral interventions, crisis management skills, and early interventions for children from birth to age three.

The entire list of outcomes can be found in Appendix B.

Chapter 4 reviews the major parts of the systems of care impacting children's mental health that the New Freedom Commission (2003a) proposed as options through its Subcommittee on Children and Families (2003). They will be reviewed using the empirical research that supports or controverts the options to determine

- Whether the Commission's recommendations are empirically supported and are efficacious approaches; and
- Whether the Washington State's recommendations and implementation efforts responding to the Commission's action are empirically supported and efficacious;

Chapter 5 discusses whether federal and state policies and practices have changed, i.e., improved, to address the identified concerns arising from the three major themes—evidence-based practice, early intervention, and workforce needs—or will more fragmentation result and will gaps in services continue?

Chapter 4—Overview, Implementation, and Analysis of Application of the Commission's Recommendations by Washington State

The chapter reviews the various determinants that can impact and support the systems of care for the mental health of children, adolescents, and their families. Most subsections begin with the New Freedom Commission's policy options from its Subcommittee on Children and Families (Subcommittee, 2003). It includes federal executive action taken since the Subcommittee's report, the research in the topic area that has been published in the interim from 2002, the prevalence of the problem for the given topic at the national and Washington State level, and the actions taken to date at the federal level and in State of Washington level to address the federal options and to meet

the state's identified needs. Each subject in the subsections is considered to be a determinant in its potential impact toward improving mental health care for children.

Parents, caretakers, or children as determinants.

The Commission's Subcommittee for Children and Families (Subcommittee, 2003) envisioned mental health care for children being aided by the strengthening of family and youth partnerships as well as family support. The Subcommittee specifically addressed the need by stating the following:

> Federal, state, and local governments should ensure that families, substitute families, and other caregivers, as well as youth, are full partners and have substantial involvement in all aspects of service planning and decision making for their children at federal, state, and local levels. (p. 3)

Its recommendations included four options:

- Implement strategies to prevent the unnecessary transfer of custody to provide care;

- Review and strengthen federal and state requirements for family participation;

- Expand support for family organizations to provide information and training; and

- Provide coverage for family support services in public and private insurance.

In comprehensive mental health care, Huang et al. (2005) recognized the need for home- and community-based services and supports because of the substantial role that family plays in a child's life and because the support provided by families and caregivers in the process of mental health care is necessary. The role includes being advocates and case managers who aid providing access to care and removing barriers. Children, too, can become self-advocates as consumers (Day, 2008).

Federal actions towards inclusion of consumers' voices. The federal government has shifted its processes to involve families in policy development (Osher & Osher, 2002). In consideration of the "real" needs of the children and their families, the U. S. Department of Health and Human Services consults with consumers, i.e., families with children with emotional disturbances, and seeks their input in grant applications. Families also have been integrated into contracts as equal partners with policy makers, administrators, and educators through the Office of Special Education Programs.

Although family support and advocacy began in the 1980s and followed the growth of community-based mental health services closely (Hoagwood, Green, Kelleher, Schoenwalk, Rolls-Reutz, Landsverk, et al., 2008, p. 74), data regarding the "infrastructure and roles of family advocacy, support and education systems in the U.S…is non-existent." Surveying directors (N = 275) of family advocacy, support, and education organizations, the researchers found that the peer-to-peer format served an important role for families in educating other families. These organizations needed more fiscal support to help pay for family-run services and approaches to connect with local mental health clinics. In addition, the directors reported a need for training for screening and assessment to improve mental health services and effective clinical practices.

Guidance on increasing help-seeking behavior by consumers. Supporting factors to increase mental health help-seeking behaviors by parents and youth are essential. Currently the research has focused on explaining the models with a dearth of empirical data in their support. In recognition of the lack of informed practice, Power, Eiraldi, Clarke, Mazzuca, and Krain (2005) suggested, after their review of research studies (N = 13), that help-seeking parents use four guiding steps to plan intervention:

- Determine child and family progress along the help-seeking continuum. Although multi-dimensional measures for this assessment are not presently available, the use of self-designed, semi-structured interviews addressing factors related to help-seeking is recommended;

- Because families vary greatly with regard to their preferences for service delivery settings, providers, and interventions, it is important for practitioners to understand the preferences of families in their community and work with neighborhood leaders to create these options;

- Families generally benefit from education about mental health conditions and strategies to address their concerns. Family education programs ought to be planned in collaboration with parents, and it is often beneficial to provide parent groups simultaneous with child groups; and

- In working with families, practitioners need to be careful to advance families into evidence-based interventions only when they are ready for them. Premature implementation of treatment may result in early withdrawal or poor adherence. (p. 201)

The reported use of mental health services increased when interviewers used specific language when querying about utilization (Reid, Tobon, & Shanley, 2008). The research compared the results of a survey that queried parents in two studies on whether they had sought mental health services for their child. In the first study, when asked whether they had "contacted a [specific] mental health clinic or agency," only 28% to 41% of the parents (N = 95) reported that contact had occurred. However, in the second study, when asked if they (N = 137) had sought help from a specified agency (i.e., a

named mental health agency) on behalf of their child, 100% reported seeking services at a 6-month follow up. Help-seeking and the documented use of services by parents for their children perhaps can be fostered with more local specific terms, although as seen by Power et al. (2005), more research is needed to inform practice in this area.

Children as advocates. Including children in the process of mental health care policy ensures accountability (Day, 2008). This movement encourages children's voices, using a bottom-up approach in providing services, although little empirical evidence showed that this policy development produced the hoped-for outcomes.

As a show of their increased voice, young leaders from across the nation at the 2009 Portland National Youth Summit drafted a Mental Health Youth Bill of Rights (See Appendix C and http://www.rtc.pdx.edu/FeaturedDiscussions/pgFD00main.php). They intend to seek its adoption by other organizations, including SAMHSA, and hope to have it displayed in doctors' offices, counseling centers, and organizations providing mental health services for persons age 14 to 25 (Portland Research and Training Center on Family Support and Children's Mental Health, 2009).

The Washington State Office of the Superintendent of Public Instruction in its Healthy Youth Survey (RMC Research Corporation, 2005) reported periodic data detailing the mental health of Washington's school children in grades 6, 8, and 10. The survey was conducted in schools as a collaborative state agency effort. The survey results showed high numbers of youth reporting concerns about their emotional and mental health, including *feelings* of depression, substance abuse, infliction of intentional injury, and suicide attempts and suicide ideation with a plan. During the compilation of the 2008 data (N = 4,000) about child and family satisfaction with publicly funded mental health

services, the Washington Institute for Mental Health Research and Training (2009)

collected data from caregivers of younger children and youth 13 and older who could

consent to receive medical or mental health services. The findings of these researchers

were that "caregivers of younger children reported greater satisfaction with participation

in treatment and staff sensitivity to culture than did youth 13 and over" (2009, ¶8). This

data displayed by graph and text format were challenging to decipher. A matrix

displaying levels of satisfaction graphed against the various identified populations with

sample numbers, including minorities and men, as noted in the text, would have been

more useful.

Children, as the major stakeholders in the mental health care processes, need to

provide their own input. Currently, the school survey has given substantial data in their

reports on their mental status. However, without taking great effort to distill their views

in all efforts, their voices become lost within the larger context.

Parents' mental health as a determinant. The health of the parent is rarely

considered during the discussions regarding reform in mental health policy for children

(Gladstone, Boydell, & McKeever, 2006; Biedel, Nicholson, Williams, & Hinden, 2004).

Nonetheless, the literature on the topic has shown that more focus must be paid to this

factor. In recognition of this concern, the federal government has included provisions for

health care for prenatal and postpartum women, something that Washington had already

implemented in its First Steps to Success program (WA DSHS, 2008c; Kendziora, 2004).

The evidence of whether this population of women has a higher prevalence of

depression over the general population remains in question. Gaynes, Gavin, Meltzer-

Brody, Lohr, Swinson, et al., (2005) conducted a meta-analysis on 30 studies on perinatal

depression. The analysis fulfilled the researchers' gold standard of having either a clinical assessment or a structured clinical interview and culled systematically from N = 109 given a full review. The available research reported 5% to more than 25% of prenatal or postpartum mothers diagnosed with depression, i.e., a common complication for this period. The variance in percentages depended upon the assessment method, timing of the assessment, and population characteristics. The researchers also noted that no reference standard to measure pregnant or postpartum mothers has yet been devised through systemic review and assessment. Gynes et al. (2005, p. 5) found a paucity of research, particularly research exploring the need to improve, expand, and better account for racial and ethnic mix on differences in perinatal depression, concluding that: "The small number and small size of relevant studies are not adequate to guide national policy"

Biedel et al. (2004, p. 46) estimated that millions of children lived with a parent or parents with a mental illness. In their study surveying just over half of the responsive state mental health agencies (N = 27), researchers found that "parenthood [was] …extremely prevalent among adults with serious mental illness." The emerging themes needed to address children with parents needing mental health care. In particular, they recommended increased funding for prevention in early years of child development, collaboration across systems, family-centered, focused preventions and interventions, and the use of multiple approaches.

Gladstone, Boydell, and McKeever (2006, p. 2546) seriously questioned the research's use of labeling children in this population as "at risk" to develop a mental illness simply because a parent had a mental illness. Nonetheless, the researchers noted that the children of these parents often remained *invisible* and little empirical evidence

existed about their outcomes. They concluded by advocating that research begins by exploring "what childhood is like for these children." Studying only one risk factor, asthma, Ortega, Goodwin, McQuaid, & Canino (2004) found that Latino parents (N = ~1,400) in Puerto Rico with mental illness reported higher levels of a history of asthma for their children. These researchers called for further exploration of the family's psychosocial and behavioral factors that perhaps contributed to the prevalence of asthma. Such a finding did suggest the need to assess and potentially intervene with prospective parents and current families with parents identified with mental illness. Interventions, such as accessible health care, can potentially increase the incidence of better outcomes for these families.

The research leads toward acknowledging the impact that family members can have on children based on that family's mental health. Nonetheless, as seen in the study by Gaynes et al. (2005), prior to recommending a national policy to screen for depression in prenatal and postpartum women, there needs to be substantially improved and expanded research, particularly to consider race and ethically mixed populations.

Specific research findings potential effect on policy. Gaskin, Kouzis, & Richard (2008) reported that the use of public subsidies by families contributed to increasing the probability that children (N = 42,000) used mental health services. The researchers questioned whether mental health services substituted for parental support and counseling. It appeared possible that the negative stressors related to the need for use of public assistance created more use of public services, or, perhaps, once a family was in a system of care, mental health assistance was made available and mental health care was used because it seemed to be a benefit.

Washington State's connection to consumers and their families. The

Washington State Board of Health (2007), in its plan, acknowledged that families help

foster the mental health of their children. The Board (cited in National Survey of

Children's Health, 2007) reported that

> ...Washington parents are concerned about the mental health of their children.
> Approximately 12% of parents...have a lot of concern about depression and
> anxiety in their 6-17 year-old children...about 21% of parents have a lot of
> concern about their children's self-esteem, and 22% have a lot of concern about
> how their children cope with stress. (p. 35)

The Board of Health (2007) recognized that the inclusion of mental health

professionals in primary care provider offices offered more support for families and

caregivers as they attempted to provide care for their children. The major approach would

be psycho-education, i.e., giving families information on how to support a child. The

Board of Health also identified the issues concerning transitioning youth suffering with

mental health problems to adulthood and the level of family.

In the State of Washington, families can access several resources in the public

mental health system. In 1996, 2003, and 2006, the Statewide Action for Family

Empowerment of Washington (WA DSHS, 2007) published "A Parents Guide to the

Public Mental Health System" online. This document provided basic information on

identifying when a child needs mental health care and how to access services. It defined

terms, clarified the processes for outpatient and inpatient treatment, outlined parents' and

children's rights, and provided tips for all of their self care. SAFE WA serves as a

clearinghouse for information for families.

Additionally, the University of Washington hosts a web site with resource links

for family and youth—Washington Kids Count. In its policy paper titled "Understanding

Family, Friend, and Neighbor (FFN) Care in Washington State: Developing Appropriate Training and Support," Brandon, Maher, Joesch, and Doyle (2002) have compiled survey results from parents, caregivers, professionals, and policy makers regarding care given by families, friends, and neighbors caring for children outside of licensed care facilities. Overall, this form of child care, including kinship care, is common; approximately 480,000 children, ages birth to age 12, use this type of care. The survey identified the need for more training on how to care for these children and recommended a pilot project to target and to assist these providers.

Washington State's efforts focus on psycho-education. Also, attention has been directed at educating consumers and their families about evidence-based practices as noted on the web sites. More direct and express approaches provided by government to connect consumers to services remained less apparent in the literature and on the web sites.

Early intervention as a determinant.

Four million infants are born each year; five million infants and toddlers live in low-income families needing special attention (Knitzer, 2007). Nonetheless, a lack of focus on prevention and early intervention for children remain a problem for these populations, as identified by the Subcommittee on Children and Families (2003) to the Commission. Early intervention in the lives of children before age five can be a preventive measure to counter negative paths found in research (Hung et al., 2005; Breitenstein, Gross, Ordaz, Julion, Garvey, et al., 2007). The protective factors of prevention have also been found to be highly effective (Kendziora, 2004). Intervention should be applied to the entire population, not just the 20% of children identified as high-

risk. Benefits inuring through early intervention can serve as a "selective application of prevention" (Kendziora, 2004, p. 330). Research data showed that the paths to success experienced by young children were ensured when their early care-giving relationships provided sufficient nurturance and support (Knitzer, 2007).

The earliest intervention for children can occur through prenatal care offered to women in their reproductive years. Ebrahim, Anderson, Carrea-deAraujo, Posner, & Atrash (2009), in a series of large studies conducted with national archival data about reproductive aged women (N = 70,917; N = 7,643; N =15,469; N = 35,586, N = 13,266), found that nearly 40% who had recently given birth were poor and possessed one or more risks for ill health. Ten percent reported poor mental and general health, and more than 33% reported harmful alcohol use. In conclusion, Ebrahim et al. (2009, p. 203) found that the "current lack of attention and burden from mental health disorders" for these women, including substance abuse and "maternal depression associated with childhood behavioral problems, poor growth, and accident" posed significant health risks to their newborns. Their findings on depression contradicted the conclusions by Gaynes et al., (2005), discussed earlier herein. Their meta-data analysis reported the need for more inclusive and expansive research regarding depression in populations of perinatal women. The later study by Ebrahim et al. (2009) did not reference the substantial 2005 meta-analysis study by Gaynes et al. (2005).

For preschool children, disruptive behavior occurred in 10% of the population and resulted in a negative impact on the development of school readiness; it often led to life-long chronic problems (Kendziora, 2004). Given the long-term significance of these

behaviors, early interventions and prevention offer important avenues for improving mental health options for children and their future potential (Kendziora, 2004).

Beginning in 1991, the U.S. Congress created mandatory early intervention programs through the Preschool Grants Program for Children with Disabilities and its successor, the Early Intervention Program for Infants and Toddlers with Disabilities, Part C, Individuals with Disabilities Act of 1997 (Kendziora, 2004). The former program targeted children with serious emotional disorders, but left the remaining 80% of the population, including those at risk, without coverage (Knitzer, 2007). In recognition and expansion of the significance of values of early intervention and prevention, the Commission, through its Subcommittee on Children and Families Health (2003, p. 5) identified seven options for early intervention and prevention:

1. Develop a collaborative state plan for early childhood mental health;

2. Provide technical assistance to states to implement a comprehensive approach to early childhood mental health services;

3. Explore the feasibility of coverage for early childhood mental health services in public and private insurance and eliminate barriers to coverage;

4. Train mental health practitioners to diagnose and treat mental health problems in young children and families;

5. Screen children birth to five for social and emotional development in primary health care visits;

6. Provide mental health screening in community health centers; and

7. Address barriers to coverage of preventive intervention services in health insurance.

The simplest approach could be to address each option separately. However, given the several approaches provided by the Commission (2003a), the lack of research, and the dearth of scholarly literature, it is possible that funding each option might contribute to fragmentation and gaps. Knitzer (2007) expressed, with chagrin, that without mainstream funding, these efforts toward prevention and intervention continue to litter the landscape without the benefit of being sustainable or replicable. Additionally, many projects "simply end" (Knitzer, p. 240); the "policy response…is faltering" (Knitzer, p. 237). To address the conundrum, Knitzer (2007) proposed offering to policymakers both guidance and justification in the allotment of limited resources with "assurances that government savings ultimately exceed costs for early intervention*"* (p. 342).

Kendziora (2004) recommended slowing the creation of any new interventions, given the more than 1,000 federal initiatives that address prevention or early intervention. Kendziora suggested following Knitzer's path in looking at "practice-to-research" by studying the "pockets of excellence" and replicating these approaches elsewhere. She also acknowledged the necessity of cultural competency and family inclusion as essential variables in further research.

Washington State's approaches to early intervention. Washington has implemented its nationally recognized "First Steps to Success" program (Arima, Guthrie, Rhew, & DeRoos, 2009; WA DSHS, 2008c; Kendziora, 2004). Targeted at increasing healthy baby outcomes in low-income families, it expanded eligibility allowances to include formerly ineligible persons. Prenatal and post-partum services were allowed for Medicaid-enrolled women. In addition to producing better prenatal use outcomes than found in past research, the study documented decreases in low birth weight babies,

particularly for Hispanic mothers. This prevention program showed the benefit of expanding Medicaid eligibility allowances, and increasing the level of care. The outcomes decreased low birth weight statistics, a risk factor in infant mortality and a factor "also associated with adverse developmental outcomes" (Arima et al., 2009, p. 49).

In addition to its First Steps to Success program, Washington State's Infant Toddler Early Intervention Program (ITEIP) focused on services for infants and toddlers, birth to three, with disabilities and developmental delays. This program was funded through the Individuals with Disabilities Education (IDEA) Act, Part C of Medicaid. The program linked the research on early intervention with enhancement of a child's development. The aim was to reduce family stress with less out-of-home placement and increased cost effectiveness. The program operates in 28 states and broadly defines eligibility for children as those demonstrating "a delay of 1.5 standard deviation or 25 % of chronological age delay in one or more developmental areas" (WA DSHS, 2009c). In Washington, approximately 32 developmental and neurodevelopment centers serve nearly 7,400 children.

Washington's web site for its Infant Toddler Early Intervention Program (ITEIP) provides an extensive list of resources for primary care providers and consumers to help identify eligible children (WA DSHS, 2009c). Resources include referral information and extensive educational data about childhood development in the multiple languages of populations residing in the state. In 2006, the Infant Toddler Early Intervention Program (ITEIP) received a federal grant through the Office of Special Education Programs to fund the Washington Child and Family Outcomes Measurement Project. The funding established a State Performance Plan, with indicators to fulfill the federal requirements to

increase the numbers of children receiving early intervention services. In conformance

with its priorities, including services of care with an Individualized Family Service Plan

for a child from 2004 to present, Washington exceeded its benchmark standards for the

majority of indicators, including the number of infants and toddlers receiving early

intervention, those demonstrating social/emotional/behavioral improvements, positive

reports of outcomes by families, and resolution of complaints. The State needs to increase

its performance in the timely provision of early intervention services, as well as

evaluation and assessment. It needs to increase the number of children receiving

transition support at age three to preschool or other community services. See Appendix D

for the most recent federal oversight review of the effort.

Washington State's Department of Early Learning (2008, 2009), established in

2006, serves children from birth through school age, particularly kindergarteners. Tasked

with early care and education of children, including the implementation of the

Washington State Training and Registry System (STARS), it identifies early care and

education professionals serving children and families. At its bilingual (Spanish) web site,

the agency provides resources for families, including access information to Head Start

and childcare. It also includes information about other programs for families.

Washington's Department of Early Learning (2009) benchmarks for the 2009 to 2010

biennium are outlined in Appendix E.

Schools as a determinant.

The Commission (2003a) recognized that school-based mental health programs

can be improved and expanded for children. In 2003, 114,000 schools served 52 million

youth (Paternite, 2005). In 1995, the U. S. Department of Health and Human Services

furthered the effort with the Mental Health in Schools Program initiative to increase the abilities of schools to address mental health concerns and work to connect the various stakeholders—from policymakers to consumers. The problems facing the role of schools in this effort continue to be the lack of a cohesive policy perspective (Centers, 2004). The researchers found that marginalization under present school policies occurs, and the intended services are often provided in an *ad hoc* manner. When budgets tighten, these efforts are seen as non-essential and become dispensable.

The Centers (2004) noted that school policy stems from its mission to educate all students. The measures of success centered on test performance, attendance, and rates of graduation (Weist & Paternite, 2006). Schools remain wary of the term *mental health* and tend to equate it with mental disorders. It is also narrowly defined because of its historical focus being on mental health assessment, clinical consultation, and treatment for those in special education (Paternite, 2005). However, when students fail at school due to mental health concerns, the mission of schools also fails. School mental health services can provide documented direct benefits, including satisfaction of stakeholders, improved emotional and behavioral functioning of students, and less need for discipline and referrals (Weist et al., 2006, p. 174).

The joint work of the Centers (2004) focused on prevention and early response. The two national centers created a set of principles and a framework to guide school personnel by having them focus their attention on mental health delivery in following ways:

- Assessing the needs of both systems and individuals;
- Translating the needs to focus on and generate new approaches;

- Gathering and developing guidance and training materials;

- Creating direct delivery systems to providers;

- Training in various venues to raise the efficacy of services; and

- Developing quality improvement strategies.

The Centers intended to apply past efforts in the field to the Commission's recommendations. Specifically, schools should offer all students access to mental health services so that they can address psychosocial and mental/physical health concerns that affect school performance. Schools can serve as the greatest access point for youth (Weist et al., 2006).

The most recent federal mandate of No Child Left Behind, a quest for accountability for a child's learning, has not fit well with the implementation of the Individuals with Disabilities Education Act (IDEA) (Centers, 2004; Cohen, Linker, & Stutts, 2006). The unfunded act, No Child Left Behind, does not ensure that "base-level needs for learning"—including physical, social, and emotional needs—are met; IDEA draws a teacher's resources away from the remaining students in order to meet the special needs of others. (Cohen et al., 2006). Attempting to address mental health issues together with these efforts requires melding their shared agendas with diminishing resources.

The Centers recognized that to incorporate mental health in schools, educators and counselors needed to do the following:

- Broaden the definition of mental health to include psychosocial concerns;

- Strengthen partnerships between home, communities, and schools;

- Stress equity considerations for all to succeed at school;

- Address the competition for limited resources; and

- Apply evidence-based practices.

Recognizing that the Internet can serve as the seminal tool to access information for reform to incorporate mental health into school management policy, the Center for Mental Health Concerns in Schools at UCLA (2004) conducted an analysis of available online resources. Specifically, the Center identified 21 sources that can help in varying degrees to transform the agenda for mental health in schools. The same theme occurred throughout, i.e., gaps were found that reflected "piecemeal and fragmented approaches" (Center, 2004, p. 14). The survey supported the need to create greater connections among the key existing centers, agencies, and organizations.

Concern exists, nonetheless, among researchers that the Commission's (2003) recommendations calling for change to connect schools with mental health do not become just "another relatively unused report" (Mills et al., 2006, p. 150). They proposed executing the following key actions:

- Create a "simple and clear message" linking psychological well-being to academic success;

- Establish a consensus defining school-based mental health services;

- Involve stakeholders and form partnerships between families and schools, particularly teachers, mental health agencies, and child welfare services having a common agenda;

- Train stakeholders to ensure empowerment and support for team efforts;

- Promote evidence-based practice, particularly gathering longitudinal data linking functioning between academics and behavior and emotional health;

- Maximize the limited and available resources between professionals and university and community settings; and

- Disburse the findings of the Commission to increase awareness.

The term *collaboration,* used throughout the reports, requires examination and definition (Cohen et al., 2006). Stakeholder involvement requires participation of families and community organizations, i.e., mental health, social services, juvenile justice, health agencies, businesses, and the faith-based communities. These groups historically have had little connection with schools. Furthermore, specialization and system interaction likely will need more than one practitioner to serve a child and family. Partnering is essential to using a systemic structure from its inception to work on behalf of a child. Cohen et al., (2006) recommended creating a governing steering body, improving communications, and meeting unmet needs with a community-service program. These recommendations could help build successful collaborations to expand school mental health (Weist, Sander, Walrath, Link, Nabors, et al., 2005).

Beyond the concerns of the Commission (2003a), special populations remain underserved. Schools can also assist to enhance the mental health of children with serious mental illness. In particular, schools can play a pivotal role because those at risk often cannot be served in their own community, despite the policy that supports service in their homes, communities, and regular classrooms (Dodge, Keenan, & Lattanzi, 2002). Children with unmet needs who are living in poverty can potentially be served better through the schools than through the current systems of care. Cappella, Frazier, Atlkins, Schoenwald, and Glission (2008) documented that of children in poverty, 18% (13 million) in 2005 benefitted cognitively, physically, socially, and emotionally from

school-based mental health using their ecological model. In a study of low-income urban children without a control group, Altkins, Fraizier, Birman, Adil, Jackson, et al., (2006) obtained data showing that the high use of joint school- and home-based services for mental health provided by teachers or parents correlated positively with academic performance. This latter study used a school-based mental health service model, Positive Attitudes toward Learning in School (PALS), a collaborative process that provided a system of care for children. Urban children in poverty remain underserved by the current mental health system (Frazier, Cappella, & Atkins, 2007)

Of note is the national "Mental Health Planning Evaluation Template" created in 2007 by the National Assembly of School-based Health Care (Harrington, Blodgett, Hertel, & Johnson, 2008). This 34-indicator measure allows schools to evaluate the quality of their mental health by looking at eight dimensions: operations; stakeholder involvement; staff and training; identification, referral, and assessment; service delivery; school coordination and collaboration; community coordination and collaboration; and quality assessment and improvement. Before an assessment, three assumptions are to be presumed: community, sponsoring organization, and school support; shared responsibility among mental health providers, the sponsoring organization, school, family, community, and youth providers; and adoption of the Principles and Goals of School-Based Health Care. (See http://www.nasbhc.org/APP/APP_SBHC_Principles1.htm).

The manual concludes with an extensive literature review on the change from community-based to school-based mental health (SBMH) care (Harrington et al., 2008). It highlighted the following six steps:

- Understand the shift from community-based to SBMH services;

- Understand the emerging models for delivering SMBH services;

- Examine the barriers to funding SMBH services;

- Determine a funding strategy;

- Identify funding sources; and

- Anticipate change as part of the funding plan (Harrington et al., p. 106).

School-based mental health services have begun to develop. However, as Paternite (2005) reported, no best practice model yet exists.

   Washington's school-based mental health policy. The Washington State Office of Superintendent of Public Instruction in its Healthy Youth Survey (RMC Research Corporation, 2005) reported periodic data detailing the mental health of Washington's school children in grades 6, 8, and 10. The survey was conducted in schools as a collaborative state agency effort. The survey results showed high numbers of youth reporting concerns about their emotional and mental health, including feelings of depression, substance abuse, infliction of intentional injury, and suicide attempts and suicide ideation with a plan.

   As a major component of its Mental Health Transformation Grant (WA Office of the Governor, 2005), Washington State's Superintendent of Public Instruction published the "Publicly Funded Mental Health and School Coordination Resource Manual" (Harrington et al., 2008). The manual provides a comprehensive review of Washington schools' assessment and planning, and it includes a summary of evidence-based practices in mental health available to address mental health and student performance from kindergarten through twelfth grade. The manual continues earlier efforts to facilitate school-based mental health begun in 2003, with the passage of legislation intended "...to

substantially improve the delivery of children's mental health services in Washington

state through the development and implementation of a children's mental health system"

(Coordination of Children's Mental Health Services, RCW 71.36.040, 2007). Expanding

the planning process for school-based mental health, the manual reported on

fragmentation within the systems' efforts that fosters illness over recovery. This quote

from the executive summary summarized the concern.

> If we are to be true to what parents and professionals have told us, one major finding defines where we are and how we need to move forward to create and expand collaborative responses to the mental health needs of children in schools. Existing solutions to mental health and school collaborations are uniquely local. There is no state level "cross-system" response to the mental health needs of school age children. Financing, eligibility standards, and the scope of problems each system is mandated to address limit the points of mutually supportive effort on behalf of children with mental illnesses. (Harrington et al., 2008, p. 4)

The authors recognized shortcomings, and, therefore, provided a template in the manual

that can be used to address the myriad of problems that deter recovery within a system.

The template that schools used included a review of the current status of services of

mental health care in schools, perceived barriers, federal supports, fiscal sources, a

summary of the Wraparound Model, with note of other evidence-based practices,

compliance with new state laws, the eight dimensions and their actions for a Mental

Health Planning Evaluation template, and the change from community-based to school-

based mental health care.

The assessment identified the strengths and challenges to the mental health

services in schools (Harrington et al., 2008), and it reported on strong collaborative

efforts. The manual enumerated examples that demonstrated promising programs, with

over 13 identified in Washington. It also provided a utilitarian summary of the

Wraparound principles, a legislative project in 2007, along with other evidence-based

practices and interventions (Harrington et al., 2008). The small projects have exemplified

delivery of mental health services that expand beyond the limits allowed under access to

care standards and those eligible for Medicaid. Personnel, especially school counselors

and nurses, have been identified as key in enhancing and sustaining communications and

relationships directly involving parents.

From interviews of public mental health leaders and stakeholders in education, the

assessment identified barriers (Harrington et al., 2008, p. 21-22). As the identified

principle barrier, the eligibility standards to authorize service for children and youth

under Medicaid "are a frustration to schools because we can't help unless the behavior is

off the charts" (Harrington et al., 2008, p.21). Without allowing Medicaid waivers

(formerly authorized until a 2003 federal rule amendment) to help parents in need of

mental health care, attempts to help the child from the home environment remain

thwarted. The final barrier addressed the need to create a common definition of *mental*

illness as used by educational professionals to address their expressed concerns.

> Where does the behavior stop and the mental health begin?
>
> A lot of the kids labeled as *learning disabled* are not, strictly speaking, LD. They are behavior kids. No wonder they have behaviors; look at the patterns of violence these kids have experienced.
>
> The ADHD label is overused because it is accessible. No matter how we cut it, it's all about the multiple disasters these kids experience before any of us are in a position to help. (Harrington et al., 2008, p. 22)

Washington is strengthening its school-based mental health services (Harrington

et al., 2008). The manual included web links to federal sites, particularly SAMHSA and

other state and private fiscal sources, and it presented a compilation of applicable new

state laws. To use schools as an access point for early intervention, policies must be

adopted that link the mental well being of students with traditional measures of school performance. The creation of collaborative efforts among the stakeholders and students must include their families.

Primary care physicians as determinants.

The Commission's (2003a) vision for mental health care has centered on recovery-oriented service systems. The term *primary care provider* often includes family doctors, pediatricians, naturopathic doctors, osteopathic doctors, and general practitioners. In accord with that vision, primary health care, particularly pediatricians, can assist in fostering this effort (Peebles, Mabe, Fenley, Buckley, Bruce, et al., 2009). Pediatricians traditionally have viewed themselves as advocates for children who have little voice in expressing their own needs (Pfefferle, 2007). Furthermore, the American Psychological Association (Honaker, 2003) advocated for the screening for mental disorders in primary health care as its final, third priority for a national agenda. Primary care providers conducted approximately one-third of the mental health evaluations in foster care.

Blount (2003) recognized that despite the logic and appearance of being inevitable, scattered and confusing evidence regarding the connection between behavioral health resources and primary care continues. Blount (2003) proposed integrating medical and behavioral health in the delivery of services.

Additionally, children remain significantly underserved for their behavioral health needs and fail to receive appropriate help (Commission, 2003b; Huang et al., 2005). Nonetheless, scientific evidence supported the efficacy of children benefitting from interventions that included psychosocial and community, and pharmacological, with one-

third of children receiving care from their primary care providers (Ringeisen, Oliver, & Menvielle, 2002). Gaps exist between research and practice. Primary care providers lack knowledge about the identification, assessment, and treatment of children's mental health disorders, such as depression, disruptive behavior, anxiety, and so on. Nevertheless, they most likely will be the prescribers of psychotropic medications in treatment.

Given the early discussions regarding fragmentation of mental health services, the need for collaboration between psychologists and primary care providers rang like a clear bell through the research literature. In the age of specialization in health care, the primary care provider often calls upon the specialist to coordinate care for the client (Knowles, 2009). Knowles called for this collaboration between these professionals, recognizing a need to create a common language and understanding of each other's cultures, e.g., eliminating jargon in communications. Collaboration can reduce fragmentation of services. Heldring (2003) spoke to convening a summit to educate the stakeholders on collaboration being key. She also called for the creation of a common vocabulary.

Pediatricians' offices generally are "universally" accepted avenues to assess and treat childhood mental health problems (Briggs, Racine, & Chinitz, 2007). They see "...more than 95% of young children as a regular source of health care," they have the greatest potential to access early interventions for children (Briggs et al., 2007, p. 485).

Pfefferle (2007) surveyed pediatricians (n = 589) in six states, including Washington, regarding their concerns in providing children's mental health. The theme of discontent about the insurance industry was pervasive. Faced with a shortage of pediatric psychiatrists, pediatricians admitted having conducted mental health care with limited knowledge and training. Their minor concerns included dissatisfaction with publicly

funded mental health systems, particularly the lack of resources or access to crisis services. Pediatricians have attempted to treat children despite feeling inadequate, playing "insurance gamesmanship" (p. 430) through diagnosis other than a mental disorder, and hiring their own mental health professional. Greater communication is needed among children's providers (Pfefferler, 2007).

To meet the demand for children's mental health needs, Blount and Miller (2009) proposed teaching collaboration between physicians and psychologists, and increasing behavioral health clinicians working in primary care termed *the co-location model*. When psychologists specializing in infant care were placed in pediatric practices, the mental health needs of children to the age of three were met with greater efficacy than in offices without psychologist specialists (Briggs et al., 2007). These researchers did not report on the efficacy of these trainings as rated by clients, however.

Australian researchers, however, designed a direct approach to early intervention screening by general practitioners for pediatric mental health care (Luk, Brann, Sutherland, Mildred, & Birleson, 2002). In 16 of 29 cases, general practitioners (N = 5) reported uncertainty about the presence of mental health problems. However, after a three-hour training session and consultation with a research clinician, they correctly identified 100% of the cases with mental health problems. Three months after the brief intervention services, 61% of the parents found it useful or very useful. Although a very small sample was studied, the positive outcomes of the study from a three-hour training session presented the potential for replication to test its external validity, given the high costs of training primary care providers to conduct early interventions.

Direct approaches have shown substantial success in providing mental health services through primary care for children, certainly far exceeding the unmet needs that range around 80% of all primary health care populations of children (Cooper, 2008). Heldring (2002) recognized three needs: educate families on how to access primary care with web sites offering viable points; address the standard barriers to access, cost, and quality of health care; and know what is being measured.

Washington's use of primary care for mental health. Washington State's proposed use of primary care providers in children's mental health care mirrors the components expressed by the federal Subcommittee on Children and Families (2003) and those found in the literature (WA DSHS, 2007; Huang et al., 2005). The identified barriers also mirror those found at the national level (WA Department of Health, 2007). Barriers include the lack of adequate physician training, lack of time during office visits, lack of resources for referral, and lack of an effective, easy-to-use screening tool.

Screening through the services of a primary care provider can occur at various stages in a child's life, including early intervention to explore mental health concerns and social-emotional delays; and use of mental health consultants who work within a provider's practice with school age and youth in transition. In addition to referrals to mental health providers, contracting and hiring a mental health professional on site within a provider's office are alternatives for direct contact care by the primary care provider at all stages.

To address the barriers, the State of Washington's Department of Social and Health Services (Hilt, 2008; Coordination of Children's Mental Health Services, RCW 76.36, 2007) developed a project titled "Partnership Access Line" to enhance mental health care through the role of primary care providers. The program established a telephone contact for immediate consultation with a child psychiatrist. The department has also developed an extensive guide that provides substantial information on billing. As well, it provides as specifics for assessment and treatment of mental health conditions for children and web links to other resources. Assessment measures for various childhood-related, mental health conditions are also provided. The guide lists recommended psychotropic medications and dosages for various disorders. Outcome data have not been published about the efficacy of the PALs program, yet.

Fiscal determinants.

From its report to the Commission, the Subcommittee on Children and Families (2003) recommended the financing of a "broad array of services and support" for this population. The recommendations include home and community-based services and individualized, family-focused, coordinated, and culturally competent supports listed in the following seven implementation options:

1. Develop a plan for Medicaid to support home and community-based services and supports and individualized care;

2. Allow families to buy into Medicaid to access intensive rehabilitative community services and supports only available through publicly-funded systems;

3. Develop strategies to better align children's mental health funding streams across systems;

4. Maximize strategies to provide coverage and mental health care to uninsured children;

5. Develop strategies to increase coverage of home and community-based services, preventive interventions, and screening in private insurance and managed care systems;

6. Demonstrate home and community-based alternatives to Medicaid-funded psychiatric residential treatment; and

7. Provide technical assistance related to more efficient and effective implementation of "Early and Periodic Screening, Diagnosis, and Treatment" (EPSDT).

Medicaid and Children's Health Insurance Program continue as the major funding sources for children's mental health. According to the American Academy of Pediatrics (2008)

- 12 million (13%) U.S. children and young adults through age 21 were uninsured during 2007;

- 8.8 million (11%) children through age 18 were uninsured during 2007, a slight decline from 9.3M (12%) in 2006. The decrease is attributed to increased enrollment in Medicaid and SCHIP;

- Close to 6 million uninsured children (almost two-thirds of those uninsured through age 18) lived in families with incomes below 200% of the federal poverty level. An estimated 1.5 million lived in families between 200% and 300% of poverty;

- Most uninsured children (6 million, 68%) were eligible for public coverage in 2007. An estimated 3.9 million (45%) were eligible for but were unenrolled in Medicaid. Also, 2.1 million (24%) were eligible for but were unenrolled in SCHIP; and

- The proportion of uninsured children varied greatly by state, ranging from a high of 22% in Texas to a low of 3% in Massachusetts in 2007.

In Washington, 15% of children were uninsured in 2007 (Kaiser Family Foundation, 2009)

Two major federal and state partnership programs—Medicaid and SCHIP—provide health insurance for low-income and uninsured children, populations identified as being underserved in the mental health care and thus more at risk (Commission, 2003b). Medicaid became available in 1965, with levels of coverage increasing over the years, based on income eligibility and the age of children. The U.S. Congress established SCHIP in 1997.

In February 2009, President Obama signed the Children's Health Insurance Program (CHIP) Reauthorization Act, authorizing an increase in coverage allowing 4.1 million additional uninsured children to receive benefits between the years 2009 to 2013 (Georgetown Center for Children and Families, 2009a). The reauthorization met several of the Subcommittee on Children and Families' options, including these key items:

- Allows coverage for moderate-income children;

- Gives states the option to cover pregnant women through two-months postpartum;

- Eliminates the five-year waiting period for legal immigrant children;

- Recognizes parity; and

- Requires EPSDT be provided for children served by Medicaid.

Furthermore, states can also cover benefits through school-based health centers. Nonetheless, the reauthorization legislation does not require mental health services, although states shall provide mental health and substance abuse services that have parity with medical and surgical benefits that can be fulfilled by the implementation of EPSDT (Georgetown Center for Children and Families, 2009a).

Many of the shortcomings seen in Medicaid and the State's Children's Health Insurance Program in providing mental health care to children have been ameliorated by new federal legislation. Thus, a review of the history of these programs provides little benefit, given the magnitude of this reauthorization measure. States now can control the implementation and application of the new measures for both programs.

Washington State's major fiscal programs for health care. In Washington, three programs provide major funding for children's health care: free insurance through Medicaid, the cost-reduced State Children's Health Insurance Program (SCHIP), and the higher premium for the state-only financed insurance (WA DSHS, 2008a). Currently, the three programs offer health insurance coverage for children up to age 19 who live in households with incomes below 150%, from 150% to 250%, and from 250% to 300% of the federal poverty level, respectively. In 1999, state legislation authorized the DSHS to plan and implement SCHIP. SCHIP is a non-entitlement program in Washington State. Eligibility is determined in accord with the same rules as Medicaid for children, except with higher income standards. Children who are eligible for Medicaid or who have any "creditable health coverage" are ineligible for SCHIP.

The State of Washington will more than double its 2009 allotment under the reauthorization act of Children's Health Insurance Program from $40.6 million to $94 million (Peterson, 2008). As of April 2009, Washington's Children's Medical Programs insurance served 655,831 persons (Georgetown Center for Children and Families, 2009b). This coverage included 452,385 children, persons aged 19 and younger, enrolled in one of the three health care programs offered for children in Washington State. This increase is almost 30% since 2004. For the same period in 2009, there were 195,499 women and children designated as medically, categorically needy, receiving additional funding support from the Family Medicaid Program (Temporary Assistance to Needy Family Households); as well, 7,947 persons were served through the Children's Medical Program and Family Medical, Pregnant Women and Disabled.

In 2008, Washington State, aligned with the federal efforts to improve access, and Washington created a new, streamlined program for SCHIP called the Apple Health for Kids. It allows a family to apply for any child and simply follow simple steps to determine eligibility. Parents use a web site checklist that compares income and family size with the requirements (WA DSHS, 2008a; Concerning Health Care, HB 2128, 2009). At the site, a child's eligibility can be determined for one of three insurance programs: no-cost insurance, premiums of $20 per month, or $30 per month per child with a maximum of $40 and $60 per family, respectively, based on levels of income. Funding is available for pregnant women. The site also provides the link to determine the annual review by families for eligibility. As a side note, the Washington State DSHS web site appears to be out of date, since its Health Kids Now program, i.e., the State Children's Insurance Program (SCHIP) web site data contradict information stated in the

aforementioned Apple Health for Kids site. House Bill 2128 (Concerning Health Care, 2009) delayed the further expansion of eligibility for the benefits package until 2010. The package includes children in lower- and middle-class families, with incomes exceeding the 300% of federal poverty level. However, since relaxing the eligibility criteria to receive health insurance for the 116,000 uninsured children in 2007 (Kaiser Health Foundation, 2009), Washington State has increased its enrollment by 55,000 children in the Apple Health for Kids program (Concerning Health Care Coverage for Children, RCW 74.09.470 & 74.09.480, HB 2128, 2009). Through its efforts to increase health-care access for children, Washington ranks within the top 13 states expanding eligibility for Medicaid and SCHIP beyond the 250% of the federal poverty level (Kaiser Health Foundation, 2009).

Screening in child welfare and juvenile justice as a determinant.

The U.S. General Accounting Office (2003) reported that child welfare directors in 19 states and juvenile justice officials in 30 counties estimated that parents had placed over 12,700 children into these systems to enable them to receive mental health services. Child Welfare Services administered by in the U. S. Department of Health and Human Services oversees several programs impacting this population. Under the Social Security Act, Title IV-B, subparts 1 and 2, and Title IV-E, states and Indian tribes can receive grant funds in support of programs that aim at "keeping families together" (Commission, 2003b, p. 19). Specifically, the program provides support to children and families eligible through the food stamp program and administers foster care or out-of-home placement. The requirements for these programs vary. See Appendix F for the history of the programs.

The Subcommittee for Children and Families (2003) recommended that populations within the child welfare and juvenile justice, and populations identified as high risk, be screened and connected with services. Specifically, the Subcommittee for Children and Families (2003) envisioned the following:

> Systematic screening procedures to identify mental health and substance abuse problems and treatment needs should be implemented in specific settings in which youngsters are at high risk for emotional disorders or where there is known to be a high prevalence of these or co-occurring mental health and substance abuse disorders. (p. 4).

The Subcommittee recommended an initial and periodic screening for both the juvenile justice and child welfare systems, and other settings and populations with known high risk, including the Medicaid population. Once the problem has been identified, the provider connects the child with the appropriate services and supports. The Subcommittee included four implementation options:

- Analyze existing tools for screening and identify mental health problems and support research to develop new tools where needed;

- Incorporate developmentally and culturally appropriate behavioral health screening into EPSDT screen;

- Improve training for professionals in schools, child care, and primary health systems to help them recognize the signs of mental health problems and take appropriate action; and

- Screen high-risk children in settings with high prevalence of mental health needs (juvenile justice and child welfare systems) and link them to services.

In 1967, the U.S. Congress added the EPSDT as an option in Medicaid insurance (Perrin, 2006). This provided a child-specific benefit allowing children to receive

preventive care, including mental health care. In 1989, the expanded coverage required states to include treatment, even if it was excluded under a state's program, for conditions discovered during EPSDT. Under the federal Children's Health Insurance Program Reauthorization Act of 2009, the debate ended the requirement that EPSDT be part of the benefit packages for children served by Medicaid (Georgetown Center for Children and Families, 2009a).

Is EPSDT efficacious? A 2007 South Carolina study of infants (N = 36,662) enrolled in Medicaid revealed clinically significant differences in reduced use of emergency services for children meeting the minimum required visits recommended under EPSDT (Pittard, Laditka, & Laditka, 2007)). Prior studies on the topic had not controlled for the requisite number of visits. More specifically, the findings showed an increase in ambulatory care visits and a decrease in more expensive emergency department services during the children's first two years. Pittard et al. (2007) assumed that states would find a reduction in use of the more expensive emergency department care to be a positive outcome of EPSDT. In a 2007 California study of 53 out of 57 counties, Snowden, Masland, Wallace, and Evans-Cuellar (2007) reported that the State of California had actively imposed the EPSDT requirement after a successful consumer led lawsuit. The study similarly showed declines in rates of emergency services with an increase in outpatient services. Crisis-care episodes also declined. Enforcement of EPSDT on its face appeared to be successful, meeting its objectives in both cases. The question remains, however, how and when is a child determined to be eligible and referred for treatment after a screen (Pittard et al., 2007)?

Foster care services.

Foster care services, the third program under Title IV-E of Social Security Act, assists children needing placement outside their home due to abuse or neglect. Specifically, it pays for maintenance of children in foster care, training foster parents and staff, and administration costs (Commission, 2003b).

Despite the federal program, a gap continues between needs and receipt of services (Romanelli, Landsverk, Levitt, Leslie, Hurley, et al., 2009; Levitt, 2009). Of the five million children referred to and investigated by child welfare agencies in the United States, half will need mental health services. More than one million children within this system received insufficient mental health care in 2001 (Levitt, 2009).

In the years 2000 and 2001, only 50% of all agencies had policies or conducted systematic, universal, mental health evaluations of children at entry into foster care (Leslie, Hurburt, Landsverk, Rolls, Wood, et al., 2003). Only 20% had some limited policies requiring some mental health evaluation aimed at nonclinical features, such as placement or type of maltreatment. Around 30% of the agencies had no policy regarding mental health evaluation for emotional or behavioral issues, suicide risk, or level of functioning. Primary care providers conducted approximately one-third of the mental health evaluations. The quality of the evaluations remains unknown.

To be evidence-based and accurately identify children with mental disorders, evaluations must comply with demonstrated methodologies that meet reliability and validity standards for the population (Levitt, 2009). The scope of this inadequacy seems huge. For instance, Levitt (2009) found only the "Strength and Difficulties Questionnaire" from a literature search of approximately 8,650 citations, while searching

terms of reliable screening instruments in child welfare and other settings. Other effective instruments have been used for screening in other settings (Levitt, 2009). No reliability or validity studies were published about these instruments for children within foster care.

In foster care literature reviews over the last 15 years, Romanelli et al. (2009) reported an increasing level of support for universal mental health screening. The American Academy of Child and Adolescent Psychiatry, the Child Welfare League of America, the American Academy of Pediatrics, and the National Academy of Science have endorsed this effort. The Best Practices Mental Health in Child Welfare Consensus Conference of 2007 provided a four-stage set of guidelines to assess children's needs when they enter foster care, i.e.,

- Within three days at placement (without need evidence-based procedures or instruments);

- By 30 days with the aid of informants, such as caregivers;

- By 60 days by a qualified mental health provider with evidence-based practices and instruments for in-depth evaluation with bio/psycho/social factors from the child's environment, including family and parent risks; and

- Ongoing screening and assessment for mental health service needs during informal visits and prior to leaving the system. Caseworkers determine if additional assessment is needed, particularly in regard to environmental changes.

These measures were aimed at developing the best management practices for screening a child within the foster care system (Romanelli et al., 2009). The new 2009 CHIP legislation will provide funding to allow states to implement EPSDT to meet the best practices identified at the conference.

Foster care in Washington State. As of 2005, Washington State reported serving 10,000 children in its foster care system compared to 511,000 children nationally in the same year (WA DSHS, 2008b). The Washington State Board of Health, in accord with the U.S. Surgeon General's (U.S. Public Health Service, 2000) report, recognized that a child's entry into the foster care system created a risk factor for mental disorders (WA Board of Health, 2007). Specifically, the higher risk for mental disorders occurs due to separation from caregivers, contact with abuse or neglect, and lack of attachment to a foster family. The Washington Board of Health (2007) also cited concerning data from a study of Washington and Oregon foster care alumni by Pecora, Kessler, and Williams (2005), who found the following:

- A disproportionate number had mental health problems...at rates higher than the same-aged general population;

- Post-traumatic stress disorder (PTSD) rates doubled for the children of U.S. war veterans; and

- Recovery rates for major depression, panic syndrome, and alcohol dependence mirrored those of the general population.... (p. 1)

In accordance with the recommendations of the Commission (2003a) and given the prevalence for mental health disorders for children in foster care, the Board of Health recommended early screening at the point of entry into the child-care system (WA Board of Health, 2007). Additional recommendations included increasing provider training and consideration of "trauma-sensitive or "trauma-informed" systems, expressly noted as *a step removed* from treatment for trauma, for the special needs of this specific population of children (WA Board of Health, 2007, p. 74).

Children receiving Medicaid benefits, including those children in foster care, are subject to the EPSDT protocols at both entry and during periodic screening for health issues for foster children (WA DSHS, 2009a). Additionally, the State of Washington (WA DSHS, 2008b) is implementing a demonstration/pilot effort to screen children at the entry point into foster care. The goal of the pilot program, called "Centers of Foster Care Health," "...is to maintain up-to-date and comprehensive medical care, with referrals to medical specialists, dental care, and mental health care" (Hilt, 2008, p. 11). Programs located in Longview, Seattle, and Spokane (projected) will screen children within 72 hours after foster-care placement and well-child exams within 30 days of placement (WA DSHS, 2008b, 2009a).

As also proposed by the Commission's Subcommittee on Children and Families (2003), Pecora, Kessler, Williams, O'Brien, Downs, et al. (2005, p. 3-4), as part of the Northwest Foster Care Alumni Study, conducted by the Casey Foundation, recommended the following:

- Increase youth and alumni access to evidence-based medical and mental health treatment;

- Help maintain placement stability, which appears to have a large positive effect on adult mental health; and

- Increase education services and experiences.

Efforts to increase the implementation of evidence-based treatments have begun for early screening, as recommended by the Subcommittee on Children and Families (2003).

Other foster care issues addressed by Washington. Since 2006, the State has extended foster care services to age 21. The state extends services for 50 youth each year

who continue postsecondary educational opportunities (WA DSHS, 2009d), thus increasing further educational opportunities for some.

The Children's Alliance (2009), a statewide organization comprising 125 groups and 9,000 members, worked to save the State's Racial Disproportionality Advisory Committee during the 2009 legislative session from budget cuts. In its 2008 study, the committee determined that Child Protective Services removed American Indian and African American children from their homes two to three times more often than it removed European American children. Nonetheless, in national research, the level of abuse and neglect in families for these groups was no higher. "Yet children of color...enter Washington's child welfare system at higher rates and stay in longer than do their white counterparts" (Children's Alliance, 2009, ¶3). In response, the 2009 Legislature funded a study to evaluate whether practices by the DSHS disproportionally removed children of color (Racial Disproportionality--Child Welfare, RCW 13.34. 2009). This effort connects closely with the Commission's concerns regarding training in cultural competency for professionals connected to the needs of children.

The state is working to meet the federal policy of early screening in the foster care system, and its efforts have been enhanced with the passage of the 2009 CHIP legislation funding EPSDT to allow for early screening. However, no information could be found on efforts to increase placement stability, nor did the Commission (2003) address this concern identified by foster care alumni in the Pacific Northwest (Pecora et al., 2005).

Juvenile justice.

The U.S. Department of Justice administers the Office of Juvenile Justice and Delinquency Prevention (OJJDP, 2009) through its Office of Justice Programs. In 2005,

the U.S. courts heard 1.7 million delinquency cases, with 56% reaching a final action. Nationally, the population of juvenile offenders in custody declined by 7% from 2002, as reported by the Office of Juvenile Justice and Delinquency Prevention in 2004. The trend has been a steady decline since the highs in the mid-1990s. Arrests, too, have declined since 1996 to 1984 levels. However, overcrowding continues, with reports of 5% of facilities that hold 15% of juveniles to have exceeded their bed capacity or they have had persons sleeping in substandard beds. The same report documented that nearly 95,000 juveniles are detained in 2,808 facilities nationally.

The intent of the juvenile justice system is "to protect youth in its custody, to protect the community, and to engage interventions that reduce crime," while the mental health system is intended to treat mental health disorders (Grisso, 2008, p. 144). Grisso questioned which system should appropriately respond to youth with serious mental disorders who engage in crime.

Exploring the prevalence of the co-occurrence of mental health problems and criminal activity, Grissio (2008) outlined significant questions regarding the mental health screening of youth that may impact public policy. Three factors contributed to youth with mental health disorders being held in juvenile custody. First, they exhibit symptoms of unmanageable and risky behaviors, i.e., impulsiveness, anger, and cognitive. Second, *socio-legal* elements, evolving out of the 1990s, decreased officials' level of authority to exercise their discretion, particularly for minor offenses by during adjudications, including considering a youth's characteristics or needs. The results were penalties, often only custody, with diminishing mental health interventions for youth with mental health concerns. Third, *inter-systemic* factors contributed to more incarceration of

this population during the reduction of mental health services in 1990s. Specifically, parents with children with serious mental health disorders turned to the system so that it could *order* mental health services. The pretrial detention centers became *de facto* mental health care or holding locations. These factors prevented a clear determination of the prevalence of the co-occurrence of juvenile delinquency and mental health disorders (Grisso, 2008).

The Subcommittee of Children and Families (2003) aimed their solution at screening for mental health disorders at the point of contact with the juvenile justice system. From the literature, one self-report instrument titled "Massachusetts Youth Screening Instrument" (MAYSI-2) has been found to be most promising in indentifying mental health needs for those youth transitioning into juvenile justice facilities (Butler, Loney, & Kistner, 2007). The researchers collected archival data on a population of juvenile males (N = 127). The instrument predicted the levels of maladjustment of juveniles during detention and determined who needed to be watched for suicide attempts. Butler et al. (2007) recommended that further research use other risk assessment measures that included parent and staff ratings, such as the Child and Adolescent Functional Assessment scale to address poor self-reporting by this population.

Can a policy of screening address other elements of receipt of mental health care? Janku and Yan (2009) remarked that youth of ethnic origins, primarily African Americans, Hispanics, Native Americans, and others, continue to be overrepresented at all points of contact in the juvenile justice systems. This fact may potentially create the practice of race being a determining factor for deciding who receives mental health care.

In their study of 3, 200 juveniles, African American (n = 1,447) and Caucasian (n = 1,763), in custody of the Missouri courts, they found no significant patterns of race and mental health treatment assignment. Janku and Yan (2009) concluded, however, that without benefit of a strong and positive support system, often missing for African American youth whose parents did not advocate on their behalf, these children did not receive orders for mental health services. Screening protocols should consider missing parent advocacy as a risk element for this group.

Janku and Yan (2009) noted that both the judge and probation officer have the potential to help identify youth at risk for mental health care. In accord, Wasserman, McReynold, Whited, Keating, Musbegovic, et al. (2008) explored the roles of the juvenile probation officer to aid in mental health care decisions. Their research findings showed *under identification* of needs by probation agency practices, with only a fraction of the juveniles being evaluated and treated for mental health. Wasserman et al. (2008) recommended the need for training of probation professionals be established within the agency policy.

Juvenile justice early screening in Washington State. Washington State identified 1,640 juveniles held in 36 facilities with 30 public holding facilities. In 2004, facilities screened 84% of the juveniles for educational needs using past academic records; Washington juveniles received health care 98% of the time (US Department of Justice, 2009).

Through its Model for Change: Systems Reform in Juvenile Justice effort, the University of Washington reported at its web site the Acuity Screen Project (¶4) on

behalf of the Juvenile Rehabilitation Administration (JRA). The entire data for the effort state:

> The purpose of the JRA Acuity Screen project is to develop a behavioral screen that will identify youth who are at risk for requiring enhanced mental health and behavioral health care during their stay in a JRA facility. The screen items are being developed empirically and from recommendations about best practices in screening so that the tool can also be used as screen for emergent needs. We are currently in the first phase of examining the predictive validity of current JRA tools and items in identifying these classes of youth. (¶4).
> Without an identified mechanism available at this time to provide early screening

for mental health concerns within the Juvenile Justice system for Washington State, the approach explored using primary care providers as a noted in that subsection herein perhaps would be the most expedient. With the caveats noted herein, training medical professionals with materials, such as the "Partnership Access Line," discussed in the subsection on primary care providers, could appear to lead to better identification of mental health needs.

Multiple service alternatives of out-of-home placement. The discussion has focused on screening for mental health care for children and youth already removed from their home. A gap in mental health care in both child welfare and juvenile justice systems existed for specialty mental health care for children facing both parental/caregiver mistreatment and those children engaged in illegal behaviors (Glisson & Green, 2006). In their study, conducted in Tennessee, they assessed children ages 4 to 18 (N = 733) using four instruments: "Shortform Assessment for Children," "Columbia Impairment Scale," "Brief Symptom Inventory," and the "Services Assessment for Children and Adolescents." Their results, using these standardized screening tools during in-home services, identified children who benefited from receiving specialty mental health care.

The point-of-contact for screening can vary, given the circumstances for each child. The research has identified several instruments found to have good external validity to identify youth at risk for need of mental health care. Training people to administer the testing is an open question. The U.S. Justice Department (2009) reported no mental health screening typically occurs, although there is substantial physical health screening. Connecting primary care givers in these settings with the screening tools identified for mental health care for youth also could foster more screening at the inception of juvenile care in a detention facility. Identification of risk for need of mental health care in these settings is a first step and addresses the policy gap identified by the Subcommittee for Family and Children for screening in child welfare and juvenile justice setting.

Cultural competence as a determinant.

According to the Commission's Subcommittee for Children and Families (2003, p. 1), the systems of care needed to address the mental health of children require "cultural competence—services and systems should be responsive to the cultural perspectives and racial, ethnic, cultural and linguistic characteristics of the diverse populations served." Without culturally competent services and systems, ethnically diverse populations face outcomes in the mental health system of "…incomplete assessments and inaccurate diagnoses that lead to poor treatment plans, unnecessary hospitalizations, over- and under-medication, and negative treatment outcomes that include higher morbidity and mortality rates" (Annapolis Coalition, 2007, p. 197).

The U.S. Department of Health and Human Services' study of research (Fortier & Bishop, 2003, p. 6) on the use of cultural competency found "that a lack of attention to

cultural issues leads to less than optimal health care." Conversely, attention to concerns

or use of "certain cultural competence interventions leads to improved outcomes."

Examples reflect that 40% of jailed inmates are persons of color (US Department of

Justice, 2009); 75% of the deaths of Native Americans and Alaskan Natives result from

violent causes—unintentional injury, homicide, or suicide—twice the rate of any other

race or ethnicity (Centers for Disease Control and Prevention, 2003); more than 40% of

Southeast Asians suffer from depression, 35% anxiety, and 14% from posttraumatic

stress disorder; Latinos have three times the uninsured rate as non-Hispanic Whites and

are noticeably missing from clinical trials (Nicholson, 1997).

The projected changes in population as reported by the U.S. Census Bureau

(2001) require greater cultural competency. In 2000, the United States population self-

reported its identities as

- 67% White,

- 13% African American,

- 1.5% American Indian or Alaskan Native,

- 4.5% Asian, Native Hawaiian, or Pacific Islander,

- 13% Hispanic, and

- 7% indicated some other race.

By 2020, 40% of the U.S. population is projected to be persons of color. Predictions for

2050 project that nearly 33% of youth under the age of 19 years will be Latino/Hispanic

American, according to the U.S. Census Bureau (2008). Rural children of color are

particularly at risk, with 46.2% African American, 43% Native American, and 41.2%

Hispanic living in poverty. Urban children of color in poverty suffer, too, despite greater availability of mental health services in cities (González, 2005).

Currently, non-Hispanic Whites comprise 76% of all psychiatrists, 95% of psychologists, 85% of social workers, 80% of counselors, 92% of marriage and family therapists, 79% of psychosocial rehabilitation practitioners, 95% of school psychologists, 84% of pastoral counselors, and 90% of female psychiatric nurses (Duffy, West, Wilk, Narrow, Hales, et al., 2004). However, the dearth of culturally competent providers can lead to misdiagnosis, inadequate or inappropriate treatment, and premature treatment termination, compounding potential and existing problems. The unmet need for providers to serve children of racially and ethnically diverse populations is severe, with no simple solutions at hand that would increase accessibility to mental health services (Huang et al., 2005). The problems can result in misdirected and unintended displacement of individuals into other social systems and fragmentation of services. The lack of a qualified mental health work force, trained to serve children in multicultural services, particularly in semi-rural and rural areas, remains a barrier to care (Harrington et al., 2008).

Gilbert, Goode, and Dunne (2007) on behalf of National Center for Cultural Competence, provided a good working definition of culture.

> Culture is the learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. It comprises beliefs about reality, how people should interact with each other, what they "know" about the world, and how they should respond to the social and material environments in which they find themselves. It is reflected in their religions, morals, customs, technologies, and survival strategies. It affects how they work, parent, love, marry, and understand health, mental health, wellness, illness, disability, and death. (p.13)

Cultural competence in the workforce. On behalf of workforce planning for the

SAMHSA, the Annapolis Coalition on Behavioral Health Workforce (Annapolis

Coalition, 2007) explored cultural competencies and disparities through its plan for the

nation. The overarching goal is "to reduce and eliminate disparities in the health care of

communities of color through the development of a culturally competent behavioral

health workforce" (p. 198). It presented the following four recommendations specific to

cultural competence in the workforce:

- Recommendation 1: Increase the recruitment and retention of people of color in the workforce, which, in addition to the conventional workforce of bachelor's-prepared, pre-doctoral, and doctoral individuals, includes the use of non-degreed professionals, consumers, family members, natural healers, and trained interpreters.

- Recommendation 2: Identify, develop, implement, and evaluate culturally competent training curricula for preprofessional trainees, service providers, consumers, family members, and nondegreed professionals, including traditional/indigenous healers and interpreters.

- Recommendation 3: Make cultural competency training a requirement for licensure and certification of professionals and interpreters.

- Recommendation 4: Establish appropriate rates of reimbursement for use of trained, culturally competent professionals, non-degreed professionals, and interpreters.

Its third recommendation is critical (Annapolis Coalition, 2007). It

institutionalizes cultural competence into the behavioral health workforce by requiring a

working knowledge of cultural competency for certification and licensing with the caveat

to not reinforce stereotypes.

Culturally competent in evidence-base practices. The push toward evidence-

based practices reflects the demand for accountability, efficiency, and improved

outcomes in assessments and interventions. Nonetheless, the practices need to include

cultural competency, given the cultural variations and diversity of the nation. Isaacs,

Huang, Hernandez, and Echo-Hawk (2005) summarized and expounded on the findings

from a 2005 national meeting including five organizations—the First Nations Behavioral

Health Association, the National Asian American Pacific Islander Mental Health

Association, the National Latino Behavioral Health Association, the National Leadership

Council on African American Behavioral Health of NAMBHA, and the Federation of

Families for Children's Mental Health, the National Alliance of the Mentally Ill (NAMI);

the federal Substance Abuse and Mental Health Services Administration (Center for

Mental Health Services and Center for Substance Abuse Treatment); and several research

centers and universities. Their meeting identified five recommendations to address

cultural competence, evidence-based practices

1. Include communities of color in developing these practices;

2. Define and require cultural competence;

3. Consider *practice-based evidence* (PBE), a critical component within
   communities of color;

4. Modify the process of developing and credentialing these practices to be inclusive
   of communities of color; and

5. Support their implementation in communities of color with resources.

The first recommendation was the most vital. A definition of *cultural competency*

needs to consider its "nuances" and variations reflective of the country of origin, level of

acculturation [plus enculturation, author], age, class, and preferred language, as well as

including the "cultural congruency among practitioners and families (Isaacs et al., 2005).

Practice-based evidence considers the external validity to the community, recognizing that current evidence-based practices align with the dominant population that measure cognition over relational or emotional approaches. A need exists to ensure that practices include recognition of strength-based approaches due to culture and language that enhance resilience and provide protective factors. Including consumers and families as well as increasing researchers of color to collaborate with the current expert voices needs to be part of the process in developing evidence-based practices (Isaacs et al., 2005).

The question of the fidelity of evidence-based practice goes to concern regarding the "active ingredient" of effective practices (Jensen, Weersing, Hoagwood, & Goldman, 2005). The researchers expressed concern about the "all-or-none" criteria of evidence-based practices without consideration of the "nonspecific factors, including engagement, empathy, therapeutic alliance, belief, and hope" (p. 70). Jensen et al., (2005) stated

> Greater caution in the use of the terms "evidence-based" and "empirically supported" are [sic] clearly warranted. If by these terms one means that a given treatment has been tested and found more effective than nothing or a waiting list, then that statement is technically accurate but may be misleading. (p. 72).

Isaacs et al., (2005) reported that taking science to practice with a community of color, particularly children, has insufficient data about the "types of adaption and modifications of an EBP that are needed...to ensure that the EBP's implementation does not further create or exacerbate mental health disparities" (p. 22). They concluded that out-of-home placement for children, incarceration, and overuse of emergency medical care "...have no 'evidence' about their ability to produce positive outcomes" (p. 22). The need remains "to operationalize" cultural competence, to support practice-based evidence, and to focus on including culture in research (Isaacs et al., 2005, p. 22).

Cultural competence as a determinant in Washington. The Transformation

Working Group, on behalf of the State of Washington (2006), conducted and compiled a

needs assessment for its Partners in Recovery project to transform mental health in the

state. The assessment found no identified state policy on cultural competence in service

delivery. Furthermore, 10% of underserved consumers voiced that services were

culturally inappropriate. Gaps in data and fragmentation existed in all categories,

including practices, training, organization, budget, and data. The Cultural Competence

Task Group provided a definition and strategies (See http://mhtransformation.

wa.gov/MHTG/strategies.shtml and Appendix G for copy of these documents). In

addition, the Transformation Working Group has an on-line training course that includes

a cultural component in its Crisis Intervention Tool Kit for use by public sector

employees, such as police officers in the field; the data sources used in the materials are

dated in the 1990s. Other sources of cultural competency measures considered in the

State of Washington Partners in Recover program could not be found.

In its 2008 estimates, the U.S. Census Bureau (2008) data on Washington State

reported the population mix as follows: 75.5% non-Hispanic Whites, Hispanics (9.8%),

Asians (6.7%), African Americans (3.7%), American Indian and Alaska natives (1.7%),

persons reporting two or more races (3.1%), and Native Hawaiian and other Pacific

Islanders (0.5%). The majority of persons of color live in the urban areas, with an

increase in Hispanic populations living in agricultural communities.

The University of Washington's Public Behavioral Health and Justice Policy

Research Center (2008) noted on its web site that cultural competency in its review of

evidence-based practices is difficult.

There is controversy as to the effectiveness of EBPs when working with diverse populations and there is no easy answer. Some experts believe that adaptations based on diversity of the population are no longer adhering to the treatment method and cannot be supported by evidence. Others believe that modifications are appropriate and necessary to treat diverse populations in question. New research indicates that adaptations of EBPs can become best practices, with sufficient data to make them evidence-based. The Models for Change project is on the cutting edge of this research. (¶ 16)

The Models for Change: Systems Reform is a juvenile justice project in four Washington counties targeted to Latino youth populations. It was discussed in the subsection on juvenile justice. The effort is a model for addressing cultural competency using evidence-based programs.

On the other end of the spectrum, the need for cultural competency is apparent. Lobbying efforts by such organizations as the Children's Alliance saved the State's Racial Disproportionality Advisory Committee during the 2009 legislative session from budget cuts (Children's Alliance, 2009, ¶3). Furthermore, in 2009, the Legislature requested a study evaluating the foster care practices, given the reports of outside placement of children of color (Racial Disproportionality--Child Welfare, RCW 13.34, SB 5882, 2009). Specifically, the State's Racial Disproportionality Advisory Committee had reported that Child Protective Services removed American Indian and African American children from their homes two to three times more often than they removed European American children from their homes. The national research, however, reported no higher levels of abuse and neglect in families for these groups. This effort exemplifies the Commission's concerns regarding training in cultural competency for professionals connected to the needs of children.

Evidenced-based practices as determinants.

The American Psychological Association (2005) defined evidence-based practice in

psychology (EBPP) as follows:

> The integration of the best available research with clinical expertise in the context
> of patient characteristics, culture, and preferences…. The purpose of EBPP is to
> promote effective psychological practice and enhance public health by applying
> empirically supported principles of psychological assessment, case formulation,
> therapeutic relationship, and intervention. (¶2)

As part of developing its policy, the APA has provided an extensive list of guidelines to

evaluate treatment (APA, 2005). See Appendices H and I for copies of the APA policy

and guidance. The term *evidenced-based practices* arises out of the demand for

accountability to use effective or evidence-based interventions (Maher, Jackson, Pecora,

Schulz, Chandra, et al., 2009; Kendziora, 2004). The Subcommittee for Children and

Families (2003) identified it as an imperative value in its vision of mental health care for

children and families, i.e., the implementation of evidence-based practices. "When state-

of-the-art, evidence-based interventions are available, families should be informed of

them, and these interventions should be made available to children and families" (p. 1).

In accord with the Subcommittee, the American Psychological Association (Marsh, 2002)

expressed as its second priority support for the New Freedom Commission: "Improve

and expand the workforce to provide evidence-based services and support." Rishel (2007,

p. 155) elaborated on the origins of evidence-based practice, noting that it evolved from

the concept of evidence-based medicine, i.e., "the best evidence can be applied to

produce the best practice decisions for optimizing client outcomes."

Huang et al., (2005) elaborating on the Subcommittee's for Children and Families

recommendation, noted that many states and communities use traditional services rather

than community-based care, making it challenging for their adoption of evidence-based services and support. They also acknowledged a lag in the dissemination and incorporation of these practices in clinical practice. External validity too remains unproven in the application of these practices to the highly diverse populations found among children and their families with their multiple needs. The move from "science to service" needs to recognize the extensive heterogeneous composition of children and families. Huang et al. (2005) also noted that these practices too often cannot be the panacea for all problems or families—some can apply, others cannot, and some do not work. The challenges remain numerous, "…bridging the gap between research and practice for evidence-based programs" (Maher et al., 2004). Nonetheless, "significant debate and a lack of consensus about what constitutes an evidence-based practice within the field of mental health and children's mental health in particular" abounds (Behan & Blodgett, 2006).

The discovery of efficacious practices starts the process, but other barriers remain. Their application with fidelity as an intervention *at all,* or as designed, continues to be a barrier (Nelson, 2004). The training of providers needs to be based on the research literature of the interventions, thus reducing the reliance on word-of-mouth and advertising. Additionally, interventions need to fit individual children within their environments, along with the skills, willingness, and perseverance of the clinician. These parameters can pose a challenge to the "uniform effective 'packaged' intervention" (Nelson, 2004, p. 323).

The definition of evidence-based practice taken from the Institute of Medicine 2001 report "Crossing the Quality Chasm: A New Health System for the 21st Century" is

"the integration of best research evidence with clinical expertise and patient values" (p. 147). When treatments produce significantly positive outcomes in two or more controlled studies, they can be considered an evidence-based work product (Gruttadaro, Burns, Duckworth, & Crudo, 2007).

The National Association on Mental Illness (NAMI) published a guide that identified evidence-based practices (Gruttadaro et al., 2007) for families. As written, the families were identifying the practices. In addition to the list of the identified practices, the guide noted specifics regarding intervention, such as length of services, barriers to receipt, systems versus individual treatment, and so on. It also advocated for families to be involved in the process of indentifying evidence-based practices. See Appendix H for listed current practices and projects within Washington State reported at the University of Washington Evidence Based Practice Institute web site.

The State of Hawaii's web site for evidence-based practice for children is noteworthy, according to the National Alliance on Mental Health's guide to families. As part of Hawaii's effort, its Department of Health has created, and continually revises, a list of current evidence-based practices for children—the "Blue Menu," named for its being just a one-page document. See http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs032.pdf for a copy of the September 2009 revision.

State of Washington identification of evidence-based practice. Washington has conducted surveys and hired consultants in an attempt to identify efficacious treatments (Behan et al., 2006; Washington Institute for Mental Health Research & Training, WIMHRT, 2008; McBride, Voss, Mertz, Villanueva, & Smith, 2007; McBride, Mertz, Voss, Villanueva, & Lawless, 2008; University of Washington, Evidence Based Practice

Institute, 2007). In 2007, the Legislature funded the Evidence Based Practice Institute in the Department of Psychiatry and Behavioral Sciences, University of Washington under HB 1088 (Coordination of Children's Mental Health Services, 2007). The Evidence Based Practice Institute at its web site identified the following four levels of research support for practices used to define the term:

> Level 1: "Best Support"
>
> Level 2: "Good Support or Moderate Support"
>
> Level 3: "Promising Practice"
>
> Level 4: "Practices with Known Risks"

See Appendix I for more information regarding the recommended supporting evidence for each level.

On behalf of the Transformation Working Group, Behan et al. (2006) in their study for WIMHRT used a definition formerly used by the American Psychological Association (1995), one similar to the Evidence Based Practice Institute's definition. The relevancy of the application of these definitions to evidence-based practices to children has been questioned, given additional factors of children's development stages, family environments, and the variety of treatment settings (Hoagwood et al., 2001).

The four consultants reported on evidence-based practice used in the state. In the first report, prepared on behalf of the Transformation Working Group, Behan et al. (2006) identified several *promising* interventions, including Diagnostic Classification of Mental Health and Developmental Disorders or Infancy and Early Childhood (DC: 0-3), Parent Infant Psychotherapy, Wraparound Services, the Fast Track Model, Functional Family Therapy (FFT), and Multi-Systemic Therapy. The authors acknowledged the

latter intervention as being the "only established or truly evidenced-based practice that exists within the children's mental health field."

McBride et al. (2007) reported on the use and fidelity of several evidence-based practices with several publicly funded social services, including the Mental Health Division, the Division of Alcohol and Substance Abuse, the Juvenile Rehabilitation Administration, and the Children's Administration. The survey's findings were difficult to track. McBride et al., through WIMHRT (2008), also publishes regular fact sheets that reflect evidence-based practices in use, i.e., Multi-Systemic Therapy (n = 610) was identified as the practice most used in 2008. Nonetheless, the chart on the fact sheet reflected that Functional Family Therapy as the more frequently used therapy for children (n = 974).

The Evidence Based Practice Institute (Institute) was established by the Legislature to be a focal point for these practices in Washington State. As part of its mandate, it has initiated the *Wraparound Model* as a pilot intervention for children (Coordination of Children's Mental Health Services, 2007), in collaboration with the educational service district boards and Regional Support Networks. Additionally, the Legislature and the State Mental Health Division directed the Institute to compile data comparing Washington's evidence-based practices with data from five other states "...known for innovations as well as the complexity or similarity of their systems to Washington State" (p. 2). The draft report identified Washington State using Multi-Systemic Therapy, Trauma-based Cognitive Behavior Therapy, and Multi-Dimensional Treatment Foster Care, Functional Family Therapy, and Wraparound fidelity studies. At its web site, the Institute also provides summaries of projects that the University of

Washington is leading or partnering with in the field of evidence-based practices. Links to more comprehensive information about each, as well as links to national effort, are provided. Local interventions for children in Washington reported at the Institute's site include evidence-based applications to juvenile justice, foster care, training providers, particularly in primary care, actions for early intervention, and the interface with schools through the Wraparound Model.

Finding Washington's data regarding evidence-based practices proved difficult. Links at the Transformation Working Group site did not connect directly to institutions of higher learning. Data were inconsistent between reports. The relevance of the interstate comparisons with the five other states needs clarification as to its application. What common elements do the five states share? Information accessibility and reliability proved also to be challenging and inconsistent respectively.

Although research is needed to address more populations and other cultural competence interventions beyond its current focus "on the impact of language or communication barriers," sufficient data exist to warrant further studies, given their costs and benefits in health care service (Fortier et al., 2003, p. 6). Given these findings, cultural competency is an overarching element in all realms of systems of care for children in mental health care, including the following determinants of evidence-based practices, workforce, and geography.

Build an adequate workforce. The Subcommittee for Children and Families (2003) envisioned partnering among the federal and state governments, national accrediting organizations, professional disciplines and organizations, licensure entities, family organizations, and universities to build an adequate workforce to deliver

children's mental health services. Specifically, the Subcommittee for Children and Families (p. 5) recommended implementing a strategic plan that develops a children's mental health workforce and addresses the workforce crisis in mental health services and research for racial and ethnic minority youth and their families.

The APA submitted testimony to the SAMHSA to help prioritize the national agenda. APA identified the following as one of the most promising recommendations: improvement and expansion "of the workforce to provide evidence-based services and supports...critically for psychological and behavioral treatments for persons at risk" (Honaker, 2003, ¶7-9).

To meet the recommendations, the mental health workforce faces extensive challenges (Huang et al., 2004). Projected demographics of the youth populations from 1995 to 2015 showed increases of 74% for Asian Americans, 59% for Latinos, 19% for African Americans, and 17% for Native Americans, and a decrease of 3% for White, non-Hispanics. With high prevalence and complexity of disorders and needs of children, particularly in rural areas, these complexities compound the problem without sufficiently trained providers (Huang et al., 2004).

Globally, a shortage of mental health care workers exists (Health Workforce Advisory Committee, 2006). Mental health care is highly labor-intensive—the workforce absorbs 80% of costs (Power, 2005)—and the need outstrips the demand due to

- Shortages of psychologists specializing in children and youth;
- Declining enrollment of psychiatric nurses and nurse practitioners in graduate training;
- Insufficient numbers of child psychiatrists;

- Too few social workers; and

- Annual attrition for child caseworkers ranging between 30-40% nationwide.

The Commission (2003a) identified values and skills to incorporate into training (Huang et al., 2004). These include empowering rather than blaming families, using team approaches to care, training front-line case mangers, using clinical applications of evidence-based practices, and compiling data that can potentially improve the quality of mental health care.

The federal government clearly can take a larger leadership role in the effort on "strategies for closing the gap" (Huang et al., 2004, p. 179). Stakeholders include state agencies of human services and community providers, institutions of higher education, professional associations and organizations, family organizations, and individuals. In the latter group, providers, educators, and consumers can lead recovery-focused programs. Continuing education for professionals increases their competence to meet the new agenda for mental health (Power, 2005).

Huang et al., (2005) recognized the importance of the field of psychology in building the transformed workforce for children. Curricula training of psychologists needs to include families in the service delivery, with an emphasis on the use of evidence-based practices in home- and community-based settings beyond exclusive office and clinical practices. Additionally, more psychologists need training to work with preschool children and their families. The use of clinical, organizational, and research-based training by psychologists "primes them well for the children's mental health policy arena" (Huang et al., 2005, p. 625).

Transforming the mental health care workforce in Washington. Mirroring the nation, the State of Washington also faces workforce shortages, particularly in rural areas. Consultants to the Transformation Working Group recognized these shortages as a measure of unmet need. Morrissey, Thomas, Ellis, and Konrad (2007, p. 3) concluded that "prescriber shortage [was] the most pronounced in low-income rural counties…." With these needs provided by outpatient providers, an increase in inpatient stays and costs has occurred (Baldwin et al., 2003, cited in Morrissey et al., 2007).

The State of Washington faces mental health workforce shortages, particularly in rural counties. Morrissey et al. (2007) saw these shortages as a measure of unmet need. In their report to the Transformation Working Group, Morrissey et al. (2007), the researchers, identified prescriber shortage in all counties, particularly in low-income rural areas. The causes of workforce shortages included "economic, social, and psychological factors, particularly low per capita income. Morrissey et al. (2007) recommended approaches used by other states to improve the quality and quantity of services, including use of consumer-centered and peer-run care, Telehealth, expansion of prescriptive authority to psychologists and advance practice psychiatric nurses, integration of mental health with primary care, and expansion of Medicaid policies for user services. With unmet needs provided by outpatient providers, an increase in inpatient stays and costs has occurred (Baldwin et al., 2003, cited in Morrissey et al., 2007).

Pursuant to HB 1088 (Coordination of Children's Mental Health Services, RCW 76.36, 2007), part of the state's mental health transformation effort, the Legislature created and funded the Evidence Based Practice Institute that initiated the University of Washington (2008) Workforce Development Task Force. The goal of this effort is to

"improve the preparation of University of Washington students to provide and support evidence-based practices (EBPs) for children's mental health when they graduate to the workforce in WA State" (¶1). Although only one video was accessible from its web site, the effort has potential to provide online resources to educate professionals on children's mental health care.

Washington's recommendations for workforce changes are strong. However, its attempts to increase the workforce for children's mental health professionals remain unfulfilled in meeting the federal options to strengthen this determinant. Psychologists, however, have been identified as having the requisite skills, and they can train to expand their role, particularly in the case of meeting the statewide shortage of prescribers (Huang et al., 2003; Morrissey et al., 2007).

Role of geography.

The Subcommittee for Children and Families (2003; Huang et al., 2005) envisioned children receiving comprehensive care in both their homes and communities. The Commission's Subcommittee on Rural Issues (2004) reported no prevalence difference between urban and rural children with serious emotional disturbances. Rural children, particularly Native American youth, have a higher suicide rate. The experience of rural health creates constraints on accessibility, availability, and acceptability that are compounded by the perceived reduced access to care.

The Commission's Subcommittee on Rural Issues (2004, cited Wagenfield et al., 1994) found that persons in rural areas receive care later in the course of a disease, a situation that causes greater symptoms and more costly, intensive treatment. Lack of transportation also reduces affordable access to services, particularly for children. Rural

areas have higher child poverty. More than half of the rural children's population (3.2 million children) lives in female-head-of-households. Particularly at risk are rural children of color, identified as 46.2% African American, 43% Native American, and 41.2% Hispanic (citing U.S. Congress, 2002).

The Federal Office for the Advancement of Telehealth offered solutions (Subcommittee for Rural Issues, 2004). However, fewer than a dozen projects exist and few have developed links to systems of care for children. No measures of performance beyond consumer satisfaction surveys and process have occurred. Insufficient data exist to measure Telehealth's ability to provide access to children.

Role of geography in Washington. The State of Washington, as part of its response to the federal initiative in planning for policy considerations to transform its mental care, funded a study to explore the issue. Strode et al. (2007) compiled the report for the state. Defining and making a distinction between the terms rural and urban continually remains problematic. Some research is based on population and land density, while other research focuses on a concept of an urban-rural continuum, with recognition of commuting patterns and proximity to a large town. Strode et al. (2007) used these various definitions throughout their report.

Geographically, the State of Washington has divided its mental health services into 13 Regional Support Networks (RSNs) (Strode et al. 2007). Four of the six rural designated Regional Support Networks rank highest for need for additional providers. Fewer licensed professionals were registered in rural areas, according to the State Department of Licensing. The numbers included 11% of psychologists, 15% of social works, 2% of marriage and family counselors, 17% of mental health counselors, and 23%

of medical doctors. No statistics to distinguish psychiatrists or child psychiatrists were included.

The Regional Support Networks with the greatest need cover the most extensive geographic area (Strode et al., 2007). Identified causes included economic, social, and psychological factors. The given per capita income was a strong predictor of need, i.e., lower-income areas had the most need. The consultant's recommendations to improve services included consumer-centered and peer-run care, Telehealth, expansion of prescriptive authority to psychologists and nurse practitioners, integration of mental health with primary care, and expansion of Medicaid policies for user services. The report used data from two Washington studies conducted for "insight." Also, the studies attempted to clarify the prevalence estimates of serious emotional disturbance in all children. The second study, published in 2006, used 1998 data to survey the supply of licensed health care professionals and found extensive shortages, particularly in rural areas (Morrissey et al., 2007).

Strode et al. (2007) noted that the prevalence of mental illness remains similar in urban and rural areas. However, the rural residents can also suffer from other chronic diseases and lack of resources. Specifically, they suffer from a lack of access and care in rural Washington. Strode and Roll enumerated the 13 following recommendations:

1. Increase inpatient beds for adults and children;

2. Increase the number of community outpatient mental health providers;

3. Allow for flexible implementation of evidence-based practices that focus on outcomes rather than process;

4. Provide transportation subsidies;

5. Expand and provide incentives toward rural mental health provider education for institutions of higher learning and rural community colleges, particularly for minorities to follow career paths and pursue mental health vocations, to facilitate their practicing in rural areas upon graduation. Provide in-service training to the current workforce;

6. Increase interdisciplinary distant learning, Telehealth, and telemedicine opportunities;

7. Support research, including the use of non-traditional practitioners, for evidence-based practices designed for rural areas;

8. Maintain early detection and prevention programs;

9. Train law enforcement and local providers in appropriate treatment of mental health problems and related behavioral concerns;

10. Develop fiscal responses to rural problems of financing;

11. Support housing and employment programs for consumers;

12. Use holistic approaches that save costs and increase convenience to consumers; and

13. Study expanding prescriptive authority of other providers of mental health services.

Mental health care in rural areas can be enhanced through the application of these recommendations. Many mirror the recommendations addressing children's needs, particularly early intervention and prevention.

As seen in the review of these various determinants, discussed in the above section, extensive efforts have occurred at the federal and state levels, as well as the

private sector, to address children's mental health. Numerous programs and efforts exist.

Connecting the myriad of points of data, providing access to the data and resource

information, and implementing the efforts in ways that meet the science-based criteria

will remain a challenge, given the considerable levels of fragmentation that exist between

the various private and government agencies and programs. Chapter 5 provides a

discussion on how well the State of Washington has implemented its plan to transform

mental health care for children.

Chapter 5—Discussion

Government policy efforts to protect children span from 1912, when President

Taft established the Children's Bureau (Tichi, 2007) to the current effort initiated by

President Bush through the New Freedom Commission's Subcommittee on Children and

Families (Huang et al., 2005). In response to the subcommittee's recommendations, the

State of Washington has attempted to chart a transformed vision in public mental health

care. The discussion focuses on how the vision has affected the care of Washington

children and their families. Has the influence of federal guidance led to a more

efficacious practice of mental health care for Washington children and families? Have the

resulting changes been appropriately and adequately based on the recent research? The

answer to these questions will help inform the practice of psychologists about efficacious

measures, assessments, and interventions for children and their families.

The State of Washington's plan to chart a transformed public policy to provide for

the mental health of children is enormous, given the fragmentation and gaps in services

(Huang et al., 2005). The projected growth in the children's population over the next

decade bodes poorly for their future health and well being for many reasons. First, the

prevalence of children without access to mental health care is great. Second, children are

placed in foster care and incarcerated in the juvenile justice system. Third, they are

challenged in school with behavioral and emotional problems and diagnosed with serious

emotional disturbance.

A myriad of departments, agencies, administrations, offices, programs, studies,

and so on form an immense infrastructure that attempts to meet children's mental health

needs. Society needs to consider mental health to be as vital as is physical health—the

stigma in seeking or maintaining mental health services also remains a compelling

deterrent to the nation's future health. Three pervasive themes emerged from the

overview, analyses, and implementation efforts of the State of Washington to transform

mental health care for care for children. They are: applications of evidence-based

practice, the implementation of early interventions, and the need for a competent work

force to provide mental health care.

Evidence-based Practice, an Oxymoron?

Definitions of the term *evidence-based practice* abound in the literature as well as

the government sources. The term evidence-based occurs in nearly every list of

recommendations. Evidence-based practice has become the professionally correct term in

the mental health industry that connotes quality and assurance of an assessment or

intervention. Nonetheless, critics fear that evidence-based practice is a poor substitute for

"measurement feedback systems" and the need for outcomes, particularly for children

(Bickman, 2008, p. 439).

Prior to the Commission's (2003a) publication of *Achieving the promise:*

Transforming mental health care in America, Hoagwood et al. (2001) reviewed the

concept of evidence-based practice, the trends, and nuances applicable to children. The authors called into question the use of the term; they were concerned about its label attaching "...an almost intuitive ring of credibility...but the ring may be hollow" (p. 1179). The problem results from the use of the term evidence-based–it "...presupposes agreement as to how the evidence was generated," its meaning, and "when and how it can be implemented" (p. 1179). However, most research with populations of children identified as evidence-based practice is merely "clinical treatment efficacy research" (p. 1179).

Evidence-based children's mental health research references services provided for referral, assessment, and case management (Hoagwood et al., 2001). Specifically, the knowledge arises from the application of scientific methods and measurement of their impact on identified outcomes for children and their families. The psychometric properties of the research, i.e., its quality, robustness, and external validity result in an evaluation or intervention being labeled evidence-based practice. In reviewing the literature, it appears that distinctions are needed between adult versus children's services in the application of evidence-based practices. Specifically, research is required about the development appropriateness for the age, the central role of the family and its context, and various service venues, such as school, out-of-home placement, and clinics (Hoagwood et al., 2001).

Of the four efforts produced by consultants on behalf of Washington State during its transformation grant efforts, the consultants identified three major practices used in the State for children as being evidence-based. Sifting through the documentation and tallying the results, the consultants identified Multi-Systemic Therapy as the most

efficacious approach (e.g., Behan et al., 2006; Hoagwood et al., 2001). Washington State, however, has placed its fiscal resources and support (Coordination of Children's Mental Health Services, RCW 76.36, HB 1088, 2007) behind the "Wraparound Process," a national effort being spearheaded by the University of Washington. Hoagwood et al. (2001) reported that studies have found that the "Integrated Community-based Treatment" that they referenced as "wraparound" is both efficacious and cost effective in improving adjustments, reducing negative behavior, and increasing stability for children in out-of-home placement. Washington consultants and Hoagwood et al. (2001) identified a third intervention, "Family-focused Treatment," as being an effective intervention in controlled trials for specific problems. Hoagwood et al. (2001) noted, however, that the latter intervention is often combined with medication management. Medication management has a checkered history in Washington.

The Transformation Working Group and the Legislature raised cautionary notes about the use of psychopharmacology in children ages five and under. Also, a dire shortage of medical prescribers in rural areas of the state was noted. Little mention of the use of psychotropic mediations as an evidence-based practice could be found in the consultants' reports about evidence-based practice in the State. Nonetheless, Hoagwood et al. (2001) noted that 3.5 million children—and the number is increasing—received psychotropic medication prescriptions through outpatient physician care.

Hoagwood et al. (2001) also reported the need for individual care in the use of psychotropic medication prescriptions. For example, medication *treatment as usual* for ADHD had superior clinical outcomes when using "systematic titration to the optimal dosage" that were associated with participation in a medication treatment group (p.

1184). In the Washington State outreach effort to assist children through the program called Partnership Access Line (Hilt, 2008), physicians have been provided a comprehensive guide that includes a decision tree for ADHD that lists two branches—mono-therapy medication treatment for severe cases, including substance abuse, and psychosocial interventions only for milder cases. The guide also bluntly stated that "preschoolers have some normal hyperactivity/impulsivity: recommend skepticism if diagnosing ADHD" (p. 27). Given the findings by Hoagwood et al. (2001), reports of superior outcomes for dual therapies, and the need to consider developmental stages of children, the guidance does not report effective treatment. It also does not consider developmental concerns with its use of a non-professional tone and language that dances away from the primary element of evidence-based practice, i.e., a child's development at the time of the intervention. Combining behavioral and physical health interventions as seen in the Partnership Access Line does not meet evidence-based practice elements identified in the research.

Washington State's selection and funding of the Wraparound Model as an evidence-based practice, particularly in partnership with schools, leaves one to ask why this practice is being adopted over any of the others, and why the venue is in public education? Hoagwood et al. (2001) identified its efficacious use in foster care as an intervention for children.

At its web site, the University of Washington summarized its wraparound research and its on-going evaluation process. The intervention has been recognized by the State's consultants to be a "promising" effort (Behan et al., 2006). However, no rationale has been provided about why this choice is preferable over the other interventions. A

search to locate a user-friendly summary or figure to explain the intervention concluded at a web site that listed a 770-page document on the wraparound model. Why the University of Washington would fail to provide an accessible delineation of the model remains a mystery. Certainly, the mystery deepens after finding that the National Alliance on Mental Illness published a clear, brief summary of the intervention in its family guide (Gruttadaro, 2007). In the description of the intervention at its web site, the University of Washington researchers acknowledged that historically the wraparound practice has resulted in an "absence of standards and fully described practice procedures... [that] hindered development of a wraparound research base and frustrated providers, administrators, and families" (University of Washington, p. 5). Kendziora (2004) echoed these concerns about research not reaching practitioners, but remaining removed to the ivory tower: "Practitioners who are absorbed in the daily demands of service...often have not found the time to read the journals that could support their work. When they do turn to the literature, they too often find it impenetrable or irrelevant" (p. 339). The exploration of the wraparound model selected as a promising evidence-based practice still seems to require further empirical support to justify so much State focus of time and resources. With the limited resources of our State, the focus should remain on research paths that seem much more promising.

The practitioner looking for guidance on evidence-based practice published by the APA (2005) faces the challenge of sifting through the document's fine print, eight pages, and 21 criteria and their subsections. The document begins with that often asked question about a treatment: "How well does the intervention work?" (p. 1053), and it proceeds to discuss the dimensions of the clinical utility of a practice and how to create guidelines for

an intervention. The article is not user-friendly for the busy practitioner who attempts to discern the best evidence-based practice to use.

As mentioned, the most helpful document published by the National Alliance on Mental Illness (Gruttadaro, 2007) for families outlined interventions identified as being evidence-based. It uses a straightforward approach. In approximately one page, a reader gets a description of the intervention, its average length of treatment, what the intervention is effective for, and barriers to its availability. The practitioner seeking to understand the availability of evidence-based practice interventions for children would find this publication helpful as an initial step. For example, it describes wraparound services delivery in its four stages. Families learn that the case manager should have approximately 30 cases, in addition to theirs.

The final component for consideration for evidence practice entails looking at the pervasive multicultural element brought to the fore by the 2001 Surgeon General's report "Mental Health: Culture, Race and Ethnicity," available to the Commission during its deliberations. The lack of voice and barriers for ethnic and cultural groups in samples of psychotherapy research populations challenge the research community (Bolling, 2002). The policy for funding guidance to receive National Institute of Health's biomedical and behavioral research projects requires representation of women and members of minority groups in clinical research (US DHHS, 2007). Bolling (2002) acknowledged this requirement as admirable, due to the historical exclusions of these groups in recruitment. Nonetheless, psychotherapy as a discipline arises from mainstream culture rather than samples from non-mainstream individuals. The problem articulated by Bolling (2002) goes deeper:

> Non-acculturated peoples often perceive their problems so differently that a behavioral intervention in a research setting is a nonsensical solution. If we succeed in recruiting subjects whose ancestry is non-mainstream but who are mainstream culturally, we are not sampling diversity in the relevant variable of interest in behavioral research, namely culture. (p. 23)

Isaacs et al. (2005) created a template to include cultural competence in evidence-based practice. Although the Huang et al. (2005) specifically identified the need for culturally competent care, as well as evidence-based practice that is "guided by experience, clinical judgment, and family preference" (p. 618), all need potential components of cultural competency.

Washington State's response to this call is sketchy at best. Two items were found—a cultural responsive tool kit for police officers in crisis intervention, with research cited from the 1990s buried deep within the training materials at the Transformation Working Group web site, and a one-paragraph acknowledgement of the controversy surrounding cultural competency at the University of Washington's Public Behavioral Health and Justice Policy site. A third intervention titled "Models for Change" listed at the University of Washington site purports to be examining cultural competency, particularly to the Latino community, in an evidence-based program for screening and assessment in juvenile justice. In its early stages of development, the research team has posted the needs assessment at its web site (Walker et al., 2009). Including communities of color in a research design is the most important element in creating culturally competent evidence-based practices (Isaacs et al., 2005). The initial assessment report on Models for Change reflected a cursory notion to include the Latino population in its design and development, i.e., "the...survey was developed in close collaboration with local community members" (p. 7). Prime Time is a program being

implemented with youth of color in the juvenile justice system. See Appendix H for projects reported by the University of Washington at its web site. Overall, Washington State is using nationally defined and recognized evidence-based practice as it has reported in areas of mental health services for children. More current information and greater connections are needed between medical and behavioral interventions that are evidence-based. The State needs to focus its reporting efforts in a more user-friendly manner similar to the NAMI guide for families. With approximately 25% of the State's population people of color (U.S. Census Bureau, 2008), the efforts that addressed cultural competent evidence-based practices need implementation. Nationally, the term *evidence-based* needs to be reformed to reflect standards that meet psychometric properties. Those include science into practice by determining efficaciously based interventions whose constructs are externally valid. Lastly, "'non-specific therapeutic factors,' including the effects of attention, positive regard, and therapeutic alliance" discussed by Jensen et al, (2005, p. 53) need to be researched and considered in treatment effects as mediators of change.

In its 2006 needs assessment (Kohlenberg et al.), the State recognized that few incentives encouraged providers to use evidence-based practices. The problem still has not been addressed. Furthermore, public policy needs to clarify the definition of evidence-based practice to ensure that it provides efficacious outcomes reflected by the voices of the consumers of services.

Never Too Early to Intervene

Washington identified early intervention and screening as the paramount goal in its needs assessment, with schools and primary care providers identified as the major

points of access (Kohlenberg et al., 2006). The federal transformation effort targeted

children in child welfare programs, including foster care and juvenile justice. Washington

State has responded to both needs.

Early intervention services were provided to pregnant women through 12 months

postpartum in Washington's nationally recognized as effective "First Steps to Success"

program (WA DSHS, 2008c; Kendziora, 2004). The program also has shown beneficial

effects, including fewer low birth weight babies, a risk for adverse developmental

outcomes. Additionally, in its federal grant compliance review, Washington's Infant

Toddler Early Intervention Program (ITEIP), which assists children and their families

with disabilities and development delays, reported compliance, meeting its measures on

the majority of its indicators. Nonetheless, compared nationally to similar programs,

Washington ranked in the lower 10% of similar state programs in the identification of

infants (22nd out of 24 states) and toddlers (20th out of 25 states) identified for

eligibility. Remarkably, the federal compliance review reported neither measure as

problematic, although the facts speak for themselves. A third effort implemented in 2006,

created a new Department of Learning in the State to aid in training care providers

licensed by the State for children from birth through kindergarten. It also provides

clearinghouse functions and disburses information to families regarding resources,

including childcare and other public/ private partnership efforts in early learning, such as

Thrive by Five. These three major efforts, particularly the latter, point to Washington's

commitment to early intervention mechanisms. However, the results remain to be seen,

particularly given the low levels of expectation from the federal compliance review.

School remains out. Using schools to access early intervention for children's mental health remains a distinct challenge, according to the extensive body of research (Centers, 2004). Any effort to have schools facilitate the process of early intervention will require a cohesive policy change in priorities. Both objective measures and outcomes, specifically those linking current measures of school performance—i.e., test results, attendance, rates of graduation, and students' psychosocial and mental and physical health—must be included. Efforts that currently exist to incorporate school-based mental health are fragmented and ad hoc, with little connection of the entities and little ability to provide the necessary information (Centers, 2004). There needs to be collaboration among the numerous stakeholders, including students, their families and community families, i.e., mental health, social services, juvenile justice, health agencies, businesses, and the faith-based community.

Washington State compiled a comprehensive review manual on school-based mental health on behalf of the Transformation Working Group. A surprising omission was its lack of recommendations for action. It is recognized as "...a resource for paraeducators, counselors, mental health agency staff, school administrators and healthcare providers. Its goal is to help schools and mental health agencies better understand their respective roles" (Kohlenberg, 2008, p. 1). The tools have been provided. However, no blueprint for action can be found within the document and such an omission corroborates the supposition that it will become "...another unused report" (Mills et al., p. 150).

The only school-based mental health effort found in Washington that is being pushed by the Legislature (Coordination of Children's Mental Health Services, RCW

76.36, HB 1088, 2007) and implemented by the University of Washington is the Wraparound Model. Although identified as a promising evidence-based practice, it remains unclear as to how the effort is being fostered in Washington schools.

A natural fit appears to exist between schools and accessing care for children's mental health (Weist et al., 2006). Nonetheless, as Paternite (2005) reported, no best practice model yet exists to use school as a determinant to access care for children's mental health.

Primary care extended. Starting in April 2008, Washington State initiated its Partnership Access Line (Hilt, 2008) connecting primary care providers with telephone access to a child psychiatrist. In addition, an extensive guidance document was published that includes psychological assessment measures and dosages recommended for psychotropic medications. As a concern, the information lists medication for preschool children, despite little evidence to support its use (Aebi, 2009). In addition, no black-box, off-label use warnings are present in the data issued by the U.S. Food and Drug Administration regarding anti-depressants and their link to an increase in suicidal risk in children and youth (US DHHS, 2004). Furthermore, distribution and administration of assessments without supervision by a licensed psychologist trained for the measure pose an ethical question (APA, 2002, ¶9.07). Lastly, with legal and ethical considerations for both state and federal entitlements for children identified with ADHD, i.e., clinicians need to inform families about entitlements and advise caregivers and schools involved with services for these children (Smith, Barkley, & Shapiro, 2007). Psychologists trained to work with children populations know and understand these implications and potential repercussions. Thus, the guidance document prepared for primary providers needs to be

implemented in collaboration with appropriate professionals, with particular attention given to details.

Additionally, as noted above, concern exists about the data in the document, specifically, the reporting on treatment interventions for ADHD. Outreach effort to educate primary care providers, noted at the University of Washington web site, includes a power-point presentation. However, no data were available regarding a marketing approach, nor was outcome data provided about the effort. Furthermore, insufficient data exist to measure Telehealth's ability to provide access to children. Telehealth efforts were found to be difficult to implement in rural areas (Subcommittee for Rural Issues, 2004).

One research effort (Luk et al., 2002), given its small sample, flickered a glimmer of hope in light of its short training period (a considerable cost saving) and positively reported outcomes by consumers. Exploring similar types of research as potential answers to the conundrum of how to effectively reach and train primary care providers to aid in mental health care for children could be a boon for making sure that a doctor serves the mental health needs of a child.

Fostering care on the rise. With an abysmal history revealing a lack of mental health assistance in foster care, early intervention screening in foster care has become a mandate through the 2009 CHIP legislation. EPSDT was extended to children with Medicaid benefits that would include those in foster care (WA DSHS, 2009a). Thus, early screening and intervention can be implemented throughout the nation.

However, efficacious measurement instruments to screen in foster care remain elusive (Levitt, 2009). Research is needed. Washington State, through the University of Washington, is implementing a demonstration pilot project called "Center of Foster Care

Health" in four venues in the state (Hilt, 2008). No details about the effort could be found at the University's web site or in any published literature.

The disproportional number of children of color entering foster care in the state raises the most concern (Children's Alliance, 2009, p. 3). The Legislature responded by ordering a study to evaluate DSHS practices (Racial Disproportionality--Child Welfare, RCW 13.34, HB 5882, 2009). No information could be found on efforts to increase placement stability, nor did the Commission (2003a) address this concern, which was identified by foster care alumni in the Pacific Northwest (Pecora, 2005). The need for government to engage in more studies reflects the continuing gaps in foster care services for children in the State of Washington.

What is just about juvenile justice? Screening instruments exist that show promising results, according to the research in identifying mental health needs for those youth transitioning into juvenile justice facilities, as well as assessing for poor self reporting in the population (Butler et al., 2007). Through its Models for Change: Systems Reform in Juvenile Justice effort, the University of Washington reported the Acuity Screen Project on its web site (p. 4). With another research effort on the way, a void remains to be filled.

Screening for children with specialty mental health care. Neither the federal nor state policies identified the needs of children who face both parental/caregiver mistreatment and engage in illegal behaviors (Glisson et al., 2006). Efficacious instruments have been identified (Glisson et al., 2006). Policy also needs to be established to address this gap. At a minimum, training medical doctors in conjunction

with mental health care providers to assess for mental health issues for these children could be an efficacious response.

Workforce Needs

Huang et al. (2005) recognized that an adequate work force is required, particularly the skills of psychologists. The nation and the State of Washington can be better served with an increased awareness that specifically targets psychologists and their skills in the field.

Increased cultural competency remains primary on the list of needs for the workforce (US DHHS, 2006a). The State's assessment found no identified state policy on cultural competence in service delivery (Kohlenberg et al., 2006). Furthermore, 10% of underserved consumers voiced that services were culturally inappropriate. Gaps in data and fragmentation existed in all categories, including practices, training, organization, budget, and data. The Children's Alliance reported concerns about disproportionate numbers of children of color in foster care placements. Youth and minority (undefined by the literature) consumers of public mental health care benefits reported less satisfaction with staff cultural sensitivity than did the caregivers of younger children (WIMHRT, 2008). Other examples of the gaps in competence have been cited in Chapter 4.

Culturally responsive research methods and policies to address this need exist. Isaacs et al. (2005) summarized policy and practices that can foster cultural competence in research and clinical practice. In addition, implementing the four recommendations from the report prepared by Annapolis Coalition on Behavioral Health Workforce (2007), on behalf SAMHSA, will improve workforce cultural competence. These include recruiting people of color at all levels of training and service, including consumers and

traditional/indigenous healers, creating culturally competent training materials, requiring cultural competence to receive licensure and certifications, and reimbursing these same persons at appropriate rates. The third recommendation is critical: eliminate institutionalized stereotypes. Rural mental health lacks adequate services for all types of professionals who provide mental health care (Strode et al., 2007). The State recognized the shortage and its resulting need. It has also recommended actions similar to those of the Annapolis Coalition, including encouraging incentives to attract, train, and retain persons of color in the sparsely populated regions of the state. The State has also funded various projects located in rural areas. These incentives are intended to be responsive to the Transformation Working Group's recommendation to increase rural mental health services for children and their families (e.g., Models of Change). The other action to increase rural mental health is the Partnership Access Line to aid primary care providers in providing services through telephone conferencing. The University of Washington is currently facilitating a workforce development task force within its own structure. The task force features lectures and proposes other future initiatives. Outside of these efforts, no other governmental policy and action that could reduce the disparity in mental health care was found.

Limitations

The breadth covered by the Subcommittee for Children and Families left open for discussion an array of other vital areas of children's mental health that were not discussed, although they are relevant to better the mental health care of this population. Included on the list of items not covered would be a fiscal analysis, e.g., a cost comparison between purported interventions and assessments and the status quo. To

effectually change policy, stakeholders, i.e., legislators, executives, administrators, staff, and consumers need to know the bottom line costs for everything, outside of a dire emergency, given the role of economics.

The bottom-line message of the Commission (2003a) carried forward by the Transformation Working Group was recovery and resilience for consumers of mental health. These are vital to the entire effort. The document did not address either, given the necessary breadth and depth of the entire recovery model, a stand-alone dissertation.

The process used to make decisions, especially those prioritizing the Transformation Work Group's and its subgroup's recommendations, is reflective of the depth and level of consideration given to the stakeholders. Inclusive and open process in project development goes to the heart of design for research that is culturally competent (Isaacs et al., 2005). Future review of the processes needs to look closer at who made the decisions, how informed were the choices, and what process was used to select the priorities.

Additionally, the following topics received little to no discussion: dual diagnosis, other actions of SAMHSA or federal agencies outside major actions noted herein, parity, longitudinal studies, and managed care. Others that also have substantial need for mental health policy considerations for children include the 29 Native American tribes in Washington State, adopted children, those with serious emotional disturbances and developmental disabilities, immigrants, and youth in transition. The research potential remains wide open for study in these additional topics and more specific populations.

Three Challenges for Washington

The discussion touched on three areas of concern for mental health care for children in Washington State. How does each fare in their efficacy when viewed more critically?

Intervention.

Three early intervention efforts were reviewed herein and are being implemented in Washington: Two remain on the starting blocks and the third shows promise. Although the first effort meets most of its federal compliance requirements, a closer examination revealed that the State's ITEIP ranks in the lower 10% of similar state programs that identify and serve children with mental disabilities or developmental delays from birth to age three. In the second example, the State's newly created Department of Learning (2008, 2009) reported extensive goals with no mention of collaboration with Head Start. However, leaders in early intervention, such as Knitzer (2007), recommended modeling early intervention practices after the federal Head Start program. The third example is a national forerunner in early intervention, i.e., First Steps to Success program developed in Washington. This effort identified, intervened, and reduced low birth weight outcomes, i.e., a developmental delay risk for infants. It was particularly successful with Hispanic mothers; however, the intervention failed to improve low birth weight outcomes for African American infants. These three efforts in early intervention, although showing promise, particularly the latter one, provide only a flicker of hope that the effort at the administrative level is attempting to implement the current push in policy toward primary and secondary actions in child mental health care. Future review of whether these efforts flourish and improve greater positive outcomes at

the conclusion of the State's five year, incentive grant in 2011, should provide valuable information toward viewing their potential efficacy.

Evidence-based practice.

Has Washington State fulfilled the current standards for evidence-based practice as discussed? The answer is no. As discussed earlier, the Legislature (Coordination of Children's Mental Health Services, RCW 76.36, HB 1088, 2007) identified *one* "promising practice," i.e., the wraparound process, to service seriously emotional or behavioral disturbed children from a study by the Washington State Institute for Public Policy (WSIPP). Specifically in the legislative history, the Legislature noted the "...legislative intent...is...to place an emphasis on early identification, intervention, and prevention with a greater reliance on evidence-based and promising practices" (2008, p. 2). It directed the Department of Social and Health Services to contract for both new and expanded wraparound process services in not fewer than six sites. It also acknowledged this intervention as the most cost-effective approach with benefits for seriously emotional or behavioral disturbed children. The Legislature in its House Bill Report (Coordination of Children's Mental Health Services, RCW 76.36, HB 1088, 2007) concluded on the basis of public testimony that two counties' Regional Support Networks in Washington State, which used the wraparound process, reported the lowest use of inpatient psychiatric services for children.

The University of Washington received the contract to implement the wraparound process effort. However, at its web site, the University of Washington defined a promising practice as a Level 3 effort. Levels 1 and 2 practices are superior to Level 3 given their histories of clinical trials and good and moderate supporting evidence,

respectively; Level 4 practices have known risks. Thus, the Legislature placed all its support behind a lesser efficacious, a Level 3 practice.

Furthermore, in 2006, the Legislature had directed DSHS to implement another evidence-based intervention, Multi-Systemic Therapy (WSIPP, 2009). WSIPP (Aos, Phipps, Barnoski, & Lieb, 2001). It was identified as "truly evidence-based" and the most the cost effective as compared to other emerging or promising practices, particularly for juvenile justice. Neither web site at the Transformation Working Group or Evidence Based Practice Institute (except providing links to licensed teams of Multi-Systemic Therapy) had noted the State's 2006 pilot effort for Multi-Systemic Therapy. Washington's data on this effort appeared at the MST Services' web site in South Carolina during a search for its level of efficacy, i.e., Level 1 (See http://www. mstservices.com/cost_effectiveness.php; Hawaii Department of Health, 2009). The legislative history within HB 1088 (Coordination of Children's Mental Health Services, RCW 76.36, 2007) contained no reference to this earlier pilot project. Despite the notations of project providers at the University of Washington, access to comprehensive data regarding the State's efforts in fostering evidence-based practice in mental health care for children continues to be sketchy.

Expressly supporting the wraparound process for the serious emotional or behavioral disturbed child at risk for residential or correctional placement, or psychiatric hospitalization, the Legislature (Coordination of Children's Mental Health Services, RCW 76.36, 2007) supported a "promising practice." It also acted without regard to its limited application for use with youth populations in another venue (foster care) (Hoagwood et al., 2001) and as a designated Level 3 practice. The Legislature appeared

to act with insufficient knowledge and with an inadequate cost benefit analysis.

Nonetheless, the earlier effort, implementation of Multiple-Systemic Therapy proved

challenging to track. The results for both pilots remain unknown until publication of their

final reports. Results are to be available by December 2009 for Multi-Systemic Therapy

and December 2010 for the wraparound process (WSIPP, 2009). Access to evidence-

based practice data has not met the actions in the State's plan (WA DSHS, 2006).

Washington's efforts toward implementing evidence-based practices for children lack

both focus and centrality in locating general, specific, and status data, symptomatic of

continued fragmentation and gaps.

Cultural competency.

The term cultural competency arose on every action list. In accordance,

Washington's Transformation Working Group's Cultural Competency Task Group

created an extensive list of competencies (See Appendix G). However, the

Transformation Working Group deferred acting (with no action yet noted) on these

competencies. (See http://mhtransformation.wa.gov/MHTG/strategies.shtml).

Furthermore, extensive publications exist on the topic in both the literature and on web

sites for institutions of higher education. These include self-assessments, learning tools,

and justification for this competency (e.g., Georgetown Center for Children and Families,

http://www11.georgetown.edu/research/gucchd/nccc/). At its web site, Georgetown

University also provided a system for grading levels of cultural proficiency ranging from

the destructive (0), incapacity (F), blindness (D), pre-competence (C), competence (B), to

proficiency (A). To provide more context and clarity for each proficiency level, I

assigned letter grades to the original scale. How does Washington rate on this scale?

Two separate reviews by the Washington State Disproportionality Advisory Committee (2008) and the WSIPP (2008), as directed by the 2007 Legislature, reported that the State has a greater than national prevalence rate of youth of color placed and remaining in foster care. Also, applying Georgetown's Center for Children and Families standards of review and grading several of the prominent examples of cultural competency seen in Washington's transformation actions, these findings appear to continue destructive cultural practices and fail the to meet the Georgetown standards. In response to the WSIPP 2008 study, the Legislature (rather than mandating corrective action) directed yet another study to determine why DSHS' disproportionality exists (Racial Disproportionality--Child Welfare, RCW 13.34, SB 5882, 2009). "Controlling for poverty, geography, age of the child, and other factors using regression analysis still indicated disproportionality at many points in the child welfare system" (Miller, 2008). Given the data and process regarding this issue, the Legislature's inaction and weak reaction reflects cultural incapacity, appearing "to foot drag," and earns it a grade of F. The next example is the *single* paragraph addressing cultural diversity at the State's Evidence Based Practice Institute's web site; it too can be rated as a cultural incapacity with a F grade. Furthermore, the Transformation Working Group's tabling of the recommendations of its Cultural Competency Task Group (See Appendix G) until the second grant year (i.e., 2008 with no further action to date) also reflects, at a minimum cultural incapacity, another F grade. Finally, the Transformation Working Group's needs assessment identified 76 languages in the State, omitting English, ironically revealing its own blindness to the dominant spoken tongue and earned it a D grade. The State ranked poorly with below average grades for cultural competency in any of the examples.

Given these disappointing results, an enormous need exists. The need requires greater understanding, practice, and dissemination of data regarding substantive efforts toward prevention and early interventions and evidence-based practices. Particularly, the need requires an inculcating of cultural competence throughout the systems of mental health care for children from policy makers to clinicians. These efforts can help fulfill and begin to address the fragmentation and gaps within the mental health care for children existing within the State.

How Psychologists Can Positively Impact Policy

Policy, like culture, invisibly surrounds and creates impacts in the field of psychology, much as water and its clarity sustains the fish that swim in it, although they cannot recognize it. How can psychologists learn about the penumbra of cultural competency and public policy over their psychological work in the mental health care for children? Suggestions include the following:

- Strengthen the training of budding psychologists to include course work directly aimed at cultural competency in research design, assessments, and interventions taught by persons trained and knowledgeable about the topic;

- Advocate amending the multicultural guidelines for the American Psychological Association to use operative verbs, thus, removing the euphemistic terms "are encouraged to" and "strive to" (APA, 2002c), thereby, giving them more impact and substance in application;

- Require a separate examination on cultural competency similar to testing for jurisprudence to attain licensure (Annapolis Coalition, 2007);

- Publish clearinghouse materials that advance the current literature on cultural competency and the status of advancement of evidence-based practices;

- Require clinicians to stay abreast of the above noted advance materials culled from current literature as an ethical practice in the field of psychology in addition to seeking appropriate consultation and supervision, as appropriate;

- Submit editorials to appropriate psychology journals on the topic of the transformation of children's mental health policies to educate psychologists about actions they can take to advance the transformation plans at the state and national levels;

- Require degree programs to teach substantive units on mental health public policy that include services delivery, current assessments and interventions regarding underserved populations of children, workforce distribution, and definitions and identification of evidence-based practice; and

- Date all web site documentation noting the date at web sites purporting to support policy mandates in these topic areas, thus maintaining a timely record that informs the reader as to the currency of the information.

Implementation of these actions can familiarize and foster participation by psychologists in the realm of policy development and implementation, both integral aspects of the practice of psychology. The mental health care of children begins before the tertiary treatment level, the prime focus of the clinician. Extending the focus into earlier levels at primary and secondary care, i.e., through prevention and early intervention for those identified at risk, requires change in both professional outlook and policy. The above recommendations can help lead psychologists to increase their

awareness, receptivity, and comfort in fostering, accepting, and advocating on behalf of these imperative policy initiatives.

Conclusion

To change public policy to provide for the mental health of children is no small task. Given the prevalence of underserved populations, uninformed applications of evidence-based practice, and the projected growth in the population of children during the next decade, more focus must occur. The myriad of departments, agencies, administrations, offices, programs, studies, and so on, interfacing on behalf of the mental health needs of these populations creates an immense infrastructure. Fixing the problems needs to be cost- and time-effective, as well as efficacious. Society needs to consider mental health as vital as is a person's physical health, with no stigma associated with maintaining or seeking it, particularly for the nation's future, i.e., our children's future. Psychologists can enhance their place in the effort and fulfill the roles promoted by their skills and training. Advocating on behalf of efficacious methods that address cultural competency specifically constitutes a major step in the forward direction to improve the conditions for mental health care for today's children and that of the next generation.

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Appendix A

Washington's Grant Proposal Actions for Mental Health

Care for Children and their Families

Preschool age populations

- Develop and implement a training plan for early childhood workers to recognize early signs of emotional/behavioral problems and make appropriate referrals;
- Expand the use of the Ages and Stages (0-5) Assessment in early childhood settings
- Target public education to parents of young children;
- Develop and implement a training plan for primary care physicians to screen and recognize early signs of emotional/behavioral problems and make appropriate referrals (also applies to all other age groups);
- Mandate behavioral health screening as a required part of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) exams and make it a reimbursable service (also applies to school-age group.); and
- Promote use of Individuals with Disabilities Education Act (IDEA) Parts B and E for screening and early intervention (also applies to school-age group).

School age populations

- Implement regulatory changes to facilitate school health clinics to bill Medicaid for mental health services at fair rates;
- Advance out-stationing RSN-funded mental health staff in schools;
- Educate teachers, Child Protective Service (CPS) staff, and Juvenile Rehabilitation Administration (JRA) staff in identification and referral for emotional and behavioral problems; and
- Educate parents and family members in identification of and treatment resources for emotional and behavioral problems in their children.

Transition age populations

- Educate providers and RSNs about evidence-based practices (EBP) and encourage their use regarding prevention of first break.

All ages

- Mandate the use of a common intake-screening tool to identify co-occurring mental health and substance abuse disorders upon entry into any mental health or substance abuse treatment program;
- Create incentives for the expansion of co-occurring SA/mental health capacity on the local level; and
- Develop methods for utilizing Medicaid waivers to facilitate dual licensing, dual staff certification, unified charting, and blended funding for treatment.

Source:

Washington State Office of the Governor. (2005). *Partnerships for recovery: Washington State's grant application to SAMHSA.* Olympia, WA: Author. Retrieved from http://mhtransformation.wa.gov/pdf/mhtg/MHTGrantProposal.pdf

Appendix B

Washington's Governor Frames Direction for Transformation – TWG Established

Year-2 Priorities

Governor Frames Direction for Transformation – TWG Establishes Year 2

Priorities

Governor Gregoire requested that the Transformation Work Group (TWG) review the 27 community outcome recommendations and establish three to five priorities that Washington State can focus on for year two of the transformation process. On Friday, October 13th the Transformation Work Group held a work session to establish year two priorities. After much discussion and conducting a membership voting process, three community recommendations rose to the top:

- Increased system collaboration and service integration is prevalent across all allied systems and services:
  – Reduction in silos across system boundaries
  – Increased holistic services
  – Increased cross system treatment
  –
- A system that is more proactive than reactive. Serve the WHOLE family with a full continuum of community based services, starting with prevention and early intervention. Services would be available for parent/caregivers when the child is in an out of home placement even though the parent may have lost their Medicaid coupon. There would be a wide range of available individualized services in the community that are supportive to families so they can keep their child at home and not give up custody so their child can get services. Additional services in the continuum would include respite, wraparound services, day treatment and evidence based programs. It would build on family strengths and resiliencies and support parent partnering, and is well coordinated (seamless) among the systems. Services would be available to be delivered in the family home or other community location of family preference.
-
    a) Revisit the access to care standards and open the door to access.

    b) Decrease in families seeking Voluntary Placement Agreements.

c) Increase in mental health treatment and community supports for parents/caregivers and their children to keep children in their homes or successfully return children home after an out of home placement (JRA, CLIP, CA are a few examples where children may be returning from). Increase in community supports for families that include respite, wraparound services, day treatment and evidence-based practices.

d) Increase in community services and supports for families. This includes respite, wraparound services, day treatment and evidence-based practices.

- Decreased number of people with mental illness from entering into the criminal justice system.

These three priorities are listed as number 6, 27 and 1 respectively in the 27 outcomes (*see below*) recommended by transformation subcommittees after conducting a series of public hearings. While these priorities came from specific population groups as recommendations, the TWG agreed they would broaden the scope to relate to all population groups and across all state agencies. Outcome recommendations 4, 9, and 12 were second tier priorities that will be utilized as guidance as specific strategies are developed related to the top three priorities. Implementation strategies will be presented to the TWG at their January meeting.

VOTE RESULTS FOR 10-13-2006 TWG Meeting

27 Outcomes from 7 subcommittees

These outcomes have been numbered for identification purposes only; an outcome's

specific number does NOT represent its relative priority.

(number of votes each outcome received in right hand column)

CRIMINAL JUSTICE SUBCOMMITTEE

1. Decreased number of people with mental illness from entering into the criminal justice system.	*12*
2. Increased access to mental health and substance abuse services for those within the criminal justice system.	2
3. Decreased number of people with mental health illness re-entering the criminal justice system.	0

CO-OCCURRING DISORDERS SUBCOMMITTEE

4. Consumers will have access to appropriate, quality treatment regardless of barriers and/or resources. – Services will be specific to the individual's needs – There will be access to sufficient treatment providers who trained and retained.	10
5. Affected parties are informed, educated and knowledgeable about co-occurring disorders and their recovery culture, principles and philosophy. – Peer-to-peer support is available to all who want it. – Communication between and among the parties is critical to making this successful. – Law enforcement officers receive crisis intervention training to deal with co-occurring disorders	0
6. Increased system collaboration and service integration is prevalent across all allied systems and services. – Reduction in silos across system boundaries – Increased holistic services – Increased cross-system treatment	*15*

7. Service Delivery is consumer driven and recovery focused. – There are options available outside of the current standard options such as homeopathic services.	0

YOUTH IN TRANSITION SUBCOMMITTEE

8. Consumers and family members have choices, utilize self-directed care and are sponsors, mentors and guides (i.e. peer-to-peer support). Services and supports are tailored to their cultural, community and individual needs.	3
9. a) Seamless, holistic care to include mental health, physical health and dental integrated for all youth 13 – 24 that provides for access on demand and includes early identification, intervention, housing, benefits and transition to adulthood. Systems use practices that have been known to work. b) Reduce stigma through on-going education and training about recovery and resiliency developed by consumers and family members.	10
10. Consistent access to quality services and supports available regardless of location or funding sources.	3
11. Continual quality improvement is an integral part of all systems based on feedback and involvement from youth consumers and family members.	0

ADULT CONSUMERS AND FAMILIES SUBCOMMITTEE

12. Funding is attached to the consumer, allowing the consumer, with the assistance of a recovery coach, to select and self-direct services they believe will assist them in their recovery process and to purchase these services directly. All consumers will have a choice of services in which they can become engaged that include at a minimum: – Consumer-run services of various types – Individual therapy with a qualified therapist – Clubhouse services – Case management services	10
13. State regulations will be modified to allow consumer-run entities that are independent of the community mental health agencies to provide Medicaid-eligible consumer-run services.	1

– Within five years, these services will represent 25% of all mental health services in Washington State, and – Within five years, 20% of adult consumers are employed as service providers in traditional mental health agencies and/or in the new consumer-run entities.	
14. Everyone working in the mental health system is trained and certified in psychiatric rehabilitation through college programs specially designed to provide such training. All recipients of services are also trained in psychiatric rehabilitation.	0
15. The ombudsman system is independent of the mental health system (MHD, RSNs, and provider agencies).	2
16. Consumers have access to evidence-based vocational rehabilitation services on demand that include high quality supported employment based on national standards. These programs work collaboratively with DVR to ensure employment for as many consumers as possible.	4

OLDER ADULT CONSUMERS SUBCOMMITTEE

17. Older Adults will have improved and consistent access to appropriate mental health services, including outreach to place of residence.	1
18. Mental Health services for Older Adults will be provided and funded in an integrated holistic model of care including mental health, medical, substance abuse, social services and spiritual.	2
19. There will be an increased number of service-providing individuals with professional expertise in mental health and aging.	0
20. Appropriate mental health services for older adults are coordinated across all systems of care at state, regional and local levels.	1

HOMELESSNESS SUBCOMMITTEE

21. Housing will be available immediately upon need for individuals/families.	7
22. Services are available immediately, regardless of the financial or categorical status of the individual or family, while other benefits and services are being applied for.	1
23. Continuation of services after a person has passed the crisis or transitional point (to avoid services and/or housing ending after a person is stable, decompensating back into homelessness).	4

CHILDREN, YOUTH, PARENTS AND FAMILY SUBCOMMITTEE

24. Greater availability of State-Only Funds: This would require a decrease in requirements around State-only funds and an increase in the flexible use of these funds. With that in place we would purchase with: – State-only Funds for parent organizations, mentorships – State-only Funds to serve those who are not in the country legally, non-Medicaid children/youth and families. – State-only Funds to serve working poor and people who have exhausted their insurance benefits	9
25. Youth and Family Support (this includes any caregiver family including foster, adoptive and kinship families) Increased parent and youth organizations, support groups, peer support and parent partners. Partnership involvement needs to be visible at all levels where youth and parents are always at the table; this includes parent/youth participation in client driven/directed services.	2
26. Training and Education This is inclusive of partnerships that would include parents/youth and professionals as trainers, who are responsive to cultural diversity, which goes beyond linguistics and ethnicity. – Trainings would include a basic level of information regarding mental illness and strategies and interventions about how to deal with issues as they surface. – Trainings would be targeted towards teachers, in an effort to help stabilize children and youth experiencing mental illness in the school environment. Trainings for parents, kinship caregivers, adoptive parents and foster parents would include behavioral intervention and crisis management skills. Other professionals also need to be trained and all trainings need to start early and include Birth to 3 issues.	4

27. A system that is more proactive than reactive	***14***

Serve the WHOLE family with a full continuum of community based services, starting with prevention and early intervention. Services would be available for biological parents when the child is in a dependency through Children's Administration, even though the parent may have lost their Medicaid coupon. There would be a wide range of available individualized services in the community so that families would not have come to CA for additional services, at times giving up custody.

Additional services in the continuum would include respite, wraparound services, day treatment, and evidenced based programs. It would build on family strengths and resiliencies and support parent partnering, and is well coordinated (seamless) among the systems. Services would be available to be delivered in the family home or other community location of family preference.

a. Revisit the Access to Care Standards and open the door to access.
b. Decrease in families seeking Voluntary Placement Agreements for services in CA due to mental illness.
c. Increase in mental health treatment and community supports for biological parents and their children in order to successfully return children to home after CA dependency.
d. Increase in community supports for families, that include respite, wraparound services, day treatment and evidenced based practices.

Source:

State of Washington Transformation Working Group. (2007). *Governor frames direction for transformation – TWG establishes year 2 priorities*
Retrieved from http://mhtransformation.wa.gov/MHTG/library.shtml#require

Appendix C

2009 Portland National Youth Summit Draft Mental Health Youth Bill of Rights

2009 Portland National Youth Summit Draft Mental Health Youth Bill of Rights

As a part of the 2009 Portland National Youth Summit, young adult leaders from across the United States drafted a Mental Health Youth Bill of Rights. Their vision is that this Mental Health Youth Bill of Rights will be adopted by organizations such as Youth MOVE and SAMHSA and clearly displayed in every doctor's office, counseling center, and organization that services youth, ages 14-25, with mental health needs. In an effort to strengthen this document, Youth Summit participants are asking for additional feedback and support from anyone involved in the mental health network – professionals, consumers, allies, etc. We look forward to hearing your thoughts and receiving your support!

We believe that all youth should have the following rights in their mental health care:

1) Youth have the right to be leaders of their psychiatric treatment plans. *Youth should be informed of the possible side effects of medications, how long recommended medications take to go into effect, and the possible long-term effects of recommended medication. Service providers should work with youth to explore possible alternatives to using psychiatric medication before medication is given. Communication between youth and all medical providers should be collaborative, clear, and with limited use of medical terminology.*

2) Youth have the right to evaluate their mental health services. *Mental health counselors, social workers, psychologists, and other service providers should provide opportunities for youth to evaluate the satisfaction of their services throughout the*

duration of care in a respectful and non-threatening manner. This includes evaluation of

the relationship with the provider, counseling plans, and implemented treatment models.

3) Youth have the right to service transitions that are as non invasive as

possible. *When youth are transitioning into new services, mental health programs should*

strive to make the transition as accommodating as possible for the youth. Youth should be

consulted on the ways they would like to end their relationship with the current provider

and whether they would like the current provider to share their file with their new

provider. Providers should share if there will be any changes in the costs of services

and/or insurance coverage.

4) Youth have the right to trained, sensitive treatment providers. *Youth should*

have access to mental health professionals that are familiar with the unique needs and

challenges of youth with mental health needs. All mental health professionals should

have specialized training that fosters positive youth development and support. Youth

mental health service consumers should be included in the creation and implementation

of these trainings.

Source:

Portland Research and Training Center on Family Support and Children's Mental Health.
    (2009). *Mental health youth bill of rights: The time for youth voice is now!*
    Retrieved from http://www.rtc.pdx.edu/

Appendix D

Summary of Washington's State 2007 Performance Plan Indicators Infant Toddler

Early Intervention Program (ITEIP)

Washington Child and Family Outcomes Measurement Project

Individualized Family Service Plan (IFSP)

Office of Special Education Programs

Washington State Annual Performance Report (APR) for FFY 2007

Indicator 1: Percent of infants and toddlers with IFSPs who receive the early intervention services on their IFSPs in a timely manner.

Fiscal Year	Target	Actual
FFY 2007	100%	95%
FFY 2006	100%	90%

Indicator 2: Percent of infants and toddlers with IFSPs who receive the early intervention services in the home or programs for typically developing children.

Fiscal Year	Target	Actual
FFY 2007	70%	74%
FFY 2006	70%	62%

Indicator 3: Percent of infants and toddlers with IFSPs who demonstrate improved:
- **A.** **Positive social-emotional skills (including social relationships)**
- **B.** **Acquisition and use of knowledge skills (including early language/communication**
- C. **Use of appropriate behaviors to meet their needs.**

Fiscal Year	Target	Actual
FFY 2010	TBD	N/A

Comment: FFY 2006 data available for only 4 children. FFY 2007 data available for 279 children. Confident of sufficient data to establish baseline be FFY 2010.

Indicator 4: Percent of families participating in Part C who report that early intervention services have helped the family:
- **A.** **Know the rights**
- **B.** **Effectively communicate their children's needs**
- C. **Help their children develop and learn.**

Fiscal Year	Target	Actual
FFY 2007	A. 76% know rights B. 85% effectively communicate C. 85% help children learn	A. 78% know rights B. 86% effectively communicate C. 85% help children learn
FFY 2006	A. N/A B. N/A C. N/A	A. 67% know rights B. 78% effectively communicate C. 83% help children learn

Comment: New targets have been created.

Indicator 5: Percent of infants and toddlers birth to 1, with IFSPs compared to:
>   **A.   Other States with similar eligibility definitions**
>   **B.   National data.**

Fiscal Year	Target	Actual
FFY 2007	0.80% ID and eligible	0.53% ID and eligible

Comment: Washington ranked 22nd of 24 w/similar eligibility requirements; all programs nationally 47th in 2007; 48th in 2006

Indicator 6: Percent of infants and toddlers birth to 3, with IFSPs compared to:
>   **A.   Other States with similar eligibility definitions**
>   **B.   National data.**

Fiscal Year	Target	Actual
FFY 2007	1.90% ID and eligible	1.82% ID and eligible

Comment: Washington ranked 20th of 25 w/similar eligibility; all programs nationally 43rd in 2007

Indicator 7: Percent of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting were conducted within Part C's 45-day timeline.

Fiscal Year	Target	Actual
FFY 2007	100%	90%
FFY 2006	100%	82%

Indicator 8: Percent of all children exiting Part C who receive timely transition planning to support the child's transition to preschool and other appropriate community services by their third birthday including:
>   **A.   IFSPs with transition steps and services**
>   **B.   Notification to the Local Education Agency (LEA), if child potentially eligible for Part B; and**
>   **C.   Transition conference, if child is potentially eligible for Part B.**

Fiscal Year	Target	Actual
FFY 2007	A. 100% transition steps and services	A. 96% transition steps and services
	B. 100% Notification to LEA	B. 99% Notification to LEA
	C. 100% Transition conference	C. 84% Transition conference
FFY 2006	D. 100% transition steps and services	A. 67% transition steps and services
	E. 100% Notification to LEA	B. 97% Notification to LEA
	100% Transition conference	C. 83% Transition conference

Indicator 9: General supervision system (including monitoring, complaints, hearings, etc.) identifies and corrects noncompliance as soon as possible but in no case later than one year from identification.

Fiscal Year	Target	Actual
FFY 2007	100% w/in year	87% w/in year

FFY 2006	100% w/in year	45.5% w/in year

Indicator 10: Percent of signed written complaints with reports issued that were resolved within 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.

Fiscal Year	Target	Actual
FFY 2007	100%	100%

Indicator 11: Percent of fully adjudicated due process hearing requests that were fully adjudicated within the applicable timeline.

Fiscal Year	Target	Actual
FFY 2007	100%	N/A no requests

Indicator 12: Percent of hearing requests that went to resolution sessions that were resolved through resolution session settlement agreements (applicable if Part B due process procedures are adopted).

Comment: N/A Washington has not adopted Part B due process and procedures.

Indicator 13: Percent of mediations held that resulted in mediation agreements.

Comment: No requests in FFY 2007

Indicator 14: State reported data (618 and State Performance Plan and Annual Performance Report) are timely and accurate.

Fiscal Year	Target	Actual
FFY 2007	100%	100%
FFY 2006	100%	90%

Source:

Washington State Department of Social & Health Services. (2009c). *Infant toddler early intervention program (ITEIP)*. Olympia, WA: Author. Retrieved from http://www.dshs.wa.gov/iteip/

Appendix E

Washington's 2009 Goals of the Department of Early Learning--Focus for the 2009

to 2011 Biennium

2009 Goals of the Department of Early Learning

Focus for the 2009-2011 biennium include the following:

1. Develop, in partnership with constituents, a statewide system for quality programs and services for children, birth through age 5.
2. Assess "real life" outcomes and promote accountability for children, families, and providers in all Department of Early Learning contracts and partnerships.
3. Review and revise the Washington State Early Learning and Development Benchmarks and ensure they are officially in place statewide.
4. Describe competencies/skills expected of early educators and develop a system for supporting statewide professional development.
5. Expand P-3 partnerships with OSPI [Office of Superintendent of Public Instruction].
6. Expand and renew public/private partnerships with Thrive By Five Washington and others.
7. Expand infant and toddler childcare services and account for results.
8. Expand integration of services for children with disabilities and other special needs.
9. Work cooperatively OSPI, higher education, the Infant Toddler Early Intervention Program, and the state Department of Information Services to develop a longitudinal data system for children.
10. Increase the visibility of early learning for the general public, funders and the media.
11. Reorganize Department of Early Learning around the three core constituents we serve—children, families and early childhood educators and caregivers.

Source:

Washington State Department of Early Learning. (2009, June). *Report to the Governor and Legislature.* Olympia, WA: Author. Retrieved from http://www.del.wa.gov/publications/research/docs/LegReport063009.pdf

Appendix F

Review of the Federal Program Resources for Children's Mental Health

Review of the Federal Program Resources for Children's Mental Health

This appendix provides a summary review of the programs that fund mental health services with background material on the federal efforts currently serving the mental health needs of children and families. This information will provide a foundation for further insight into the efficacy and potential determinant areas of change for the various mental health programs being administered on behalf of children and families in the State of Washington.

Historically, federal funding generally is divided between entitlement programs exempt from annual Congressional appropriation ceilings and discretionary programs that Congress funds each year (Commission, 2003b). The majority of the mental health programs are discretionary requiring an annual Congressional action. Housed in the Department of Health and Humans Services is the Substance Abuse and Mental Health Services Administration and its Administration of Children and Families (AFC). Currently ACF has five programs including regional efforts. It also oversees specific initiatives impacting this population, such as past projects in its Health Marriage Initiative and Responsible Fatherhood Initiatives for 2006 (US DHHS, 2006b). Substantial resources related to the service programs are available, and those that are applicable specifically to mental health follow:

Comprehensive Community Health Services Program for Children and Their Families

The largest funding mechanism to assist in implementing standards of care for this population is the Comprehensive Community Health Services Program for Children and Their Families Center for Mental Health Services (CMHS), Division of Service and

Systems Improvement Children, Adolescent, and Family Branch (Huang, Stroul,

Friedman, Mrazek, Friesen, et al., 2004; US DHHS, 2004). The CMHS oversees 6-year

federal grants designed to implement, to enhance, and to evaluate local systems of care

for the Comprehensive Community Health Services Program for Children and Their

Families. The systems of care can partner with other service providers including mental

health, child welfare education, juvenile justice, and other private and public

organizations. Grant efforts are intended to enhance and to provide underdeveloped

services in a given area (US DHHS, 2004).

The Comprehensive Community Mental Health Services for Children and

Families and Juvenile Justices Programs are both discretionary programs subject to

funding ceiling caps. This type of funding source can be flexible regarding the eligible

service populations and providers, and types of services covered. This allows these types

of programs to link and to coordinate with each other, reducing fragmentation. However,

the limited available funding reduces their ability to address the larger funding shortfalls

in mental health care (US DHHS, 2004).

Medicaid

The federal and state governments jointly fund the Medicaid health insurance

program to serve "the most vulnerable populations" (Commission, 2003b, p. 50). In

1998, Children comprised 18.9 million of the 41.4 million persons served by this

program. Medicaid covered 20% of all mental health services in the nation. In fiscal year

1998, total funds expended equaled $715 billion with an expected increase to $247 billion

in fiscal year 2002 (Commission, 2003b).

Each state establishes within federal guidelines the eligibility standards, benefit packages, and payment schedules. Services are available for low-income families and persons with disabilities, long-term institutional and community-based care for both older persons and persons with disabilities, and additional co-payment coverage for low-income persons receiving Medicare. States are authorized to charge nominal co-payments of beneficiaries. Within state threshold determinants of funding levels, pregnant women and children under the age of six with incomes not exceeding 133 percent (and sometimes up to 185 percent) of the federal poverty level and beneficiaries of Supplemental Security Income (see below) with income below 185 percent of the federal poverty level are eligible. Federal policy guidance for Medicaid mandates that a state provide coverage for ten categories of services specifically early and periodic screening, diagnosis and treatment for persons under 21 years old (Commission, 2003b).

State Children's Health Insurance Program

In January 2009, Congress reauthorized and expanded the funding for the State Children's Health Insurance Program (SCHIP) to increase over the next five years when it reaches $39 billion, tripling the current level. For those persons whose family income exceeds Medicaid eligibility ceilings, the federal government authorizes funding for the seven million children without health insurance (Commission, 2003b). Eligibility is determined by each state with ranges of funding for persons below federal poverty level to 350% above. More specifically, state funding can extend to those families ineligible for Medicaid and less than 300% of the poverty level ($66,000) that was formerly, 200% (44,000) and 50 percentage points above the 1997 levels set by a state. As a benchmark, the median household income is $50,000 with 60% of the household earning less than

$62,000. The program continues being funded through tobacco taxes (that will also increase). In addition, the new measure raises the eligibility income levels adding an additional 6.5 million children for a total of 13.5 million nationwide. It also allows payment for both immigrant pregnant mother and children, without the formerly required five- year wait period (Reuters, 2009).

Medicare

Under the Social Security Administration, the Medicare program offers two options: a *standard*—fee for services, and *choice*—managed-care package (6.2 billion persons, 15.7%). Standard care includes a Part A and Part B. Part A pays for hospital services at skilled nurse facilities, hospice, and some home health care, including mental health services for psychiatrists, clinical psychologists, and clinical social workers. The latter services generally require higher co-payments than medical services (50/50 versus 80/20). Furthermore, lifetime inpatient care for a specialty psychiatric hospital has a ceiling of 190 days. Part B pays for doctor care, outpatient hospital services, and other costs not provided by Part A. Beneficiaries with a work history receive Part A benefits without cost, while Part B charges a monthly premium of $54 and nominal co-payments (Commission, 2003). A third program, Medigap, often is purchased by Part A beneficiaries to cover the gaps in coverage not provided else where.

Also administered by the Social Security Administration (SSA), the Social Security Disability Insurance (SSDI) federal program is authorized to pay benefits to disabled persons and their families. In 2000, 5.9 million persons received SSDI. Of this populating, 1.5 million were disabled with a mental disorder (23%). Furthermore, SSDI benefitted 84,000 disabled adult children with mental disorders and mental retardation as

the two leading causes, respectively, of their disability. Benefit eligibility extends to persons disabled since childhood, i.e., before age 22, who were dependents of a deceased insured parent or a parent eligible for either SSDI or retirement benefits. As a note, mental disorders are the major cause of disability for workers receiving SSDI. Payments go directly from the SSA to a beneficiary (Commission, 2003b). Children deemed legally incompetent by age must have a third party payee identified to receive their payments (Cooper, Aratani, Knitzer, Douglas-Hall, Masi, et al., 2008).

Supplemental Security Income

In addition, the SSA provides individuals with funding to meet basic needs, including food, clothing, and shelter through Supplemental Security Income (SSI). In 2001, 6.7 million people, including children under age 18 (13%), received SSI. A third of all children, approximately 300,000, qualified for based on having a mental disorder that excluded mental retardation. Children's payments averaged $476 per month with state's supplementing that on average by $53. Eligibility is based on a national standard. In the same year, the federal and state governments spent $32 billion for the program including $3 billion from the states (Commission, 2003b).

Individuals with Disabilities Education Act (IDEA)

The U.S. Department of Education, Office of Special Education Programs, provides funding for 6.5 million disabled infants, toddlers, and children and youth (approximately 5.7 million) through the Individuals with Disabilities Education Act (IDEA) under the reauthorization beginning in 2005 for three years. Funding is provided to states to allow for a free public education in the least restrictive environment and also early intervention for infants, toddlers to age, and their families. The program is divided

into parts based on the age of a child: Part B Section 611 serves children ages 3 through 21, Part B 619 serves ages 3 through 5, and Part C serves the infants and children through 2 years of age and their families (Commission, 2003b, US DOE, 2009).

The federal program created an on-line site in 2006 that provides resources for using IDEA including its enabling legislation outlining the specific funding levels authorized for states increasing with time for Part B, Section: 619, subject to decisions made through the appropriations process that will double funding from approximately $13 billion in 2005, with annual increases each succeeding fiscal year, reaching $26 billion by 2012 (20 U.S.C. 1411(i), 2008). The state's funding formula ceiling are based the average per pupil expenditure in public schools with an adjustment for the population of the state (US Department of Education, 2008).

The 2005 reauthorization aligned IDEA with the No Child Left Behind Act. This effort by the federal government is intended to connect various programs. Details of the alignment measures have not been included the amendment. They have no bearing on the policy concerns particularly fragmentation and gaps in mental health service delivery for children and remain minimal to this discussion (US Department of Education, 2007). Individual eligibility to receive IDEA funding requires an evaluation by the school, and if found eligible, a service plan is prepared for that student. About 50% of this population have identified emotional and behavioral disorders, and remain at great risk of dropping out of school (Commission, 2003b).

Additional discretionary funding in this program supports development for research, demonstrations, technical assistance and distribution, staff and technologically, parent training, and information centers. These funds are available to institutions of

higher education and non-profit organizations. Funding levels for 2000 was $326 million for this discretionary program. (Commission, 2003b; US DOE, 2004)

Child Welfare

Child welfare services administered by in the Department of Health and Human Services oversees several programs impacting this population. Under the Social Security Act, Title IV-B, subparts 1 and 2 and Title IV-E, states and Indian tribes can receive grant funds in support of programs that aim at "keeping families together" (Commission, 2003b, p. 19). Specifically, the program provides support to children and families eligible through the food stamp program and administers foster care or out of home placement, respectively. The requirements for these programs vary as noted below.

In the Title IV-B, Subpart 1 program, Child Welfare Services, a grantee must address five requirements: inventory all children in foster care, establish an information system for the population, conduct case reviews, implement due process protection measures for families, and provide both in-home and permanent placement program that include prevention and reunification. This program includes necessary planning elements. To attain its goal, i.e., keeping families together, a state initiates an intervention process proceeds chronologically from prevention, to placement in foster care, support of efforts of reunification, and adoption, if the latter steps fail. No income requirements are needed for a family to be eligible for these services (Commission, 2003b).

The second child welfare program under Title IV-B, Subpart 2, is intended to Promote Safe and Stable Families (PSSF). The focus is on the family unit, balancing prevention and crisis services. Persons receive services through various sources including the courts, police, social service agencies, and health care providers. States receive grants

available for planning and service delivery to implement this program generally in 5-year increments. Funding levels national for this program exceed $300 million distributed pro rata based on the population of children receiving food stamps in the past three years.

Foster Care Services

Foster Care Services, the third program under Title IV-E of Social Security Act, provides assistance to children needing placement outside their home. Specifically, it pays for maintenance of children in foster care, and training of the program's foster parents and private agency staff, and administration costs. The program requires that one state agency administer or supervise the child welfare, foster care, and adoption assistance (Commission, 2003b).

Head Start and Early Head Start

Head Start and Early Head Start Programs funded by the Department of Health and Human Services, Administration of Children and Families are two programs serving low-income families with children from birth to age 5. These programs are noted as avenues for early intervention to a broad range of cultural appropriate services that can include mental health. In 2001, the program served more than 55,000 children under the age of three (Commission, 2003b).

Juvenile Justice

The U.S. Department of Justice administers through its Office of Justice Programs, the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Nationally, the population of juvenile offender in custody declined by 7% from 2002 as reported by the OJJDF in 2004. However, overcrowding continues, with reports of 5% of facilities that hold 15% of juveniles to have exceeded their bed capacity or had persons

sleeping in a substandard bed. The same report documented that nearly 95,000 juveniles are detained in 2,808 facilities; Washington State identified 1,650 juveniles held in 36 facilities. Arrests too had declined since 1996 to 1984 levels. In 2004, facilities screened 84% of the juveniles for educational needs using past academic records and received health care 98% of the time (US Department of Justice, 2009).

In 2007, the OJJDP awarded $383 million in formula, block, and discretionary grants to states and communities. In 2007, the formula and block grants equaled $175 million and discretionary grants, $258 million. In 2008, this changed: $124 million and $267 million, respectively were allotted for formula / block and discretionary grant funding (US Department of Justice, 2008)

Social Services Block Grant

Social Services Block Grant (SSBG) funds are awarded to states to furnish social services, including although not limited to: daycare for children or adults, protective services for children or adults, special services to persons with disabilities, adoption, case management, health-related services, transportation, foster care for children or adults, substance abuse, housing, home-delivered meals, independent/transitional living, employment services or any other social services found necessary by the State for its population. The program strives to achieve or to maintain economic self-support to prevent, reduce, or eliminate dependency; achieve or maintain self-sufficiency, including reduction or prevention of dependency; prevent or remedy neglect, abuse or exploitation of children and adults unable to protect their own interest, or preserving, rehabilitate or reunite families; prevent or reduce inappropriate institutional care by providing for community-based care, home-based care or other forms of less intensive care; and secure

referral or admission for institutional care when other less limited restrictions are

inappropriate. Congress provided $1.8 billion for this program in 2008 (US DHHS,

2008a).

SAMHSA's Role

In May 2006, SAMHA published the document "From Exclusion to Belonging:

Transforming Mental Health in American". The document provides an overview of the

next phase of the transformation called Federal Action Agenda on Mental Health.

Included among its extensive list of action items on its agenda is the award of state

mental health transformation grants (US DHHS, 2009b).

Appendix G

Washington State's Definition and Strategies for Cultural Competency

Cultural Competency Definition

By the Cultural Competence Task Group

Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system of care that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the history, language, thoughts communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious, ability or social groups. "Competence" is a dynamic process which requires consistent and ongoing attention. It implies having the capacity to function effectively as an individual and as an organization, within the context of cultural beliefs, behaviors and needs presented by consumers and other communities.

<u>Operationalizing Cultural Competency</u>

In order for Cultural Competency to be operationalized in agencies, institutions, and communities, the following items must be incorporated into the definition of Cultural and Linguistic Competency:

1. Cultural Competence is measured by the availability of sufficient numbers of duly qualified personnel and consultants for the system, to provide comparable access to and results from services provided to various communities and populations in the service area of the agency, system or community;

2. The intervention or treatment must be based on cultural values of the individual, group or groups of interest;

3. The strategies that comprise the treatment must be consistent with the values, beliefs and practices of the individual, ethnic or other cultural groups;

4. The Tribal nations must be given due respect for their sovereign status in selecting and receiving mental health service; and

5. Cultural competence requires a thorough understanding of the culture and language of limited English speaking communities, of deaf/hard of hearing, deaf/blind and other disability groups, as well as lesbian, gay, bisexual, transgender, youth, and older adults/elder communities.

Cultural Competence Task Group Strategies

Overarching Recommendation of the Group

Establish a Governor appointed ongoing **Interdepartmental Coordinating Council on Cultural Competence (ICCCC)** that will function with the authority to oversee the implementation of the Mental Health Transformation Project strategies to achieve all proposed outcomes for the Transformation Grant partners.

Oversight shall include the provision of technical assistance, advocacy and enforcement of the principles agreed upon by the Transformation Work Group (TWG) to integrate cultural competence in all aspects of the Mental Health Transformation Project activities.

The ICCCC will receive staff support from the Mental Health Transformation (MHT) project and work collaboratively to further the integration of effective cultural competence principles in the mental health system.

The ICCCC shall be composed of members or their appointees of the following agencies and communities:

➢ Two adults and two youth mental health service consumers
➢ Two parents of adult children, two parents of younger children and two older adults that are mental health service consumers
➢ Tribes
➢ Executive Directors of all four of the existing ethnic commissions – African American, Asian Pacific Islander, Hispanic/Latino and Governor's Office of Indian Affairs
➢ Culturally competent subject experts from the mental health, substance abuse, developmental disabilities, juvenile justice, adult criminal communities, Division Vocational Rehabilitation, Long Term Care and Office of the Deaf/Hard of Hearing.
➢ Other disabilities
➢ Homeless Coalition
➢ Lesbian, Gay, Bisexual and Transgender (LGBT).
➢ Committee appointees shall always be considered from all ethnic groups, gender, rural and urban populations. Intent shall be to always establish balance diversity.

Source: Washington State Transformation Working Group. (2006). *Products & reports: Task group strategies; Cultural Competency Task Group*. Retrieved from http://mhtransformation.wa.gov/MHTG/strategies.shtm

Appendix H

Washington State Evidence-Based Practices and Programs Identified at the

University of Washington

EBP	EBP Institute Projects	Projects and Grants: House Bill 1088 (Descriptions)	List of Behavioral Health & Justice Policy EBP with resources	Clinic Projects & Consultations	Individual Projects
Family Integrated Transitions /Treatment		x	x	X (juvenile justice)	
Fostering Care Assessment				x	
Fostering Hope	x				
Functional Family Therapy		x	x		
Integrated Treatment Model				x (Echo Glen)	
Models for Change					x
Motivational Enhancement Therapy		x	x		
Motivational Interviewing		x	x		
Multisystemic Therapy			x	X (Network Partner)	
Parent-Child Interaction Therapy		x	x		
Partnership Access Line*	x				
Partnerships for Success	x				
Positive Parenting Program (Triple P)		x	x		
Prime Time**				x	
Program in Assertive Community Treatment		x	x		

EBP	EBP Institute Projects	Projects and Grants: House Bill 1088 (Descriptions)	List of Behavioral Health & Justice Policy EBP with resources	Clinic Projects & Consultations	Individual Projects
Project Focus	x				x
Relapse Prevention Therapy		x	x		
Trauma-based CBT		x	x		
Trauma Mitigation for Children Program***				x	
Tri Agency Partnership	x				
Workforce Development	x				
Wraparound Model****	x				

Table notes:
* Being evaluated through the Child Psychiatry Consultation for Primary Care Study
** Under evaluation including Clinical Trial, Multisystemic Therapy, MI, & DBT; and Retrospective Study, for youth of color (N =212) [also lists Relapse Prevention on FAQ site as included] in juvenile justice system
*** Established by HB 2996, three year pilot project at twp sites
**** Evaluation project with preliminary results to at Legislature in early 2009, evaluation due mid 2009

Source:

Washington State University of Washington, Evidence Based Practice Institute. (2008). *Projects and grants: House Bill 1088 projects.* Seattle, WA: Author. Retrieved from http://depts.washington.edu/pbhjp/projects/house1088.php, http://depts.washington.edu/ebpi/projects.php, and 13 other sites that can be navigated from the last link.

Appendix I

Evidence Base Practice Institute: Evidence-Based Practices Guidelines

Evidence Based Practices Guidelines

There are four generally accepted evidence levels along the continuum of research support on which experts attempt to categorize practices, based on the body of evidence and outcomes indicated supporting each treatment method. Briefly, they are:

Level 1: "Best Support"

Level 2: "Good Support or Moderate Support"

Level 3: "Promising Practice"

Level 4: "Practices with Known Risks"

Specifically, evidence determinations are based on the following criteria:

Level 1: "Best Support" - Interventions receiving "best" support must have supporting research evidence obtained in one of the following ways:

- Two or more between-group design experiments demonstrating that treatment is superior to placebo or already established treatment
- Two or more between-group design experiments demonstrating that treatment is equivalent to an already established treatment
- Ten or more rigorous single case design experiments which demonstrate treatment efficacy In addition, all experiments must:
- Be conducted with treatment manuals
- Specify characteristics of client samples
- Have treatment effects demonstrated by at least two different investigators

    Level 2: "Good Support or Moderate Support" - Interventions receiving "good or moderate" support must have supporting research evidence obtained in one of the following ways:

- Two or more experiments showing treatment is superior to a wait-list control group

- Treatment manuals, specification of the sample, and independent investigators is not required

- One between-group design experiment utilizing manuals and a specified sample which demonstrates treatment is superior to placebo or previously established treatment

- One between-group design experiment utilizing manuals and a specified sample which demonstrates treatment is equivalent to previously established treatment

- Four or more rigorous single case design experiments utilizing manuals and specifying sample clients which demonstrate treatment efficacy

Level 3: "Promising Practice" - "Promising practices" meet the following criteria:

- Sound theoretical basis in generally accepted psychological principles or has been demonstrated to be effective with another target behavior.

- Substantial clinical-anecdotal literature indicating treatment value with the target behavior

- Generally accepted in clinical practice as appropriate for use with the target behavior

- No clinical evidence indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to likely benefits

- Book, manual, or other available writings which specify components and describe administration of treatment

Level 4: "Practices with Known Risks" - "Practices with known risks" meet the

following criteria:

- Interventions which have evidence demonstrating harmful effects of a treatment. This evidence need only be based on one study or review of the intervention.

Source:

Washington State University of Washington Evidence Based Practice Institute (EBPI). (2008). *Evidence based practices*. Seattle, WA: Author. Retrieved from http://depts.washington.edu/ebpi/

Appendix J

American Psychological Association Policy Statement on

Evidence-Based Practice in Psychology

American Psychological Statement

Policy Statement on Evidence-Based Practice in Psychology[1]

The following statement was approved as policy of the American Psychological Association (APA) by the APA Council of Representatives during its August, 2005 meeting.

Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.[2] This definition of EBPP closely parallels the definition of evidence-based practice adopted by the Institute of Medicine (2001, p. 147) as adapted from Sackett and colleagues (2000): "Evidence-based practice is the integration of best research evidence with clinical expertise and patient values." The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention.

Best Research Evidence

Best research evidence refers to scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields. A sizeable body of evidence drawn from a variety of research designs and methodologies attests to the effectiveness of psychological practices. Generally, evidence derived from clinically relevant research on psychological practices should be based on systematic reviews, reasonable effect sizes, statistical and clinical significance, and a body of supporting evidence. The validity of conclusions from research on interventions is based on a general progression from clinical observation through systematic reviews of randomized clinical trials, while also recognizing gaps and limitations in the existing literature and its applicability to the specific case at hand (APA, 2002). Health policy and practice are also informed by research using a variety of methods in such areas as public health, epidemiology, human development, social relations, and neuroscience.

Researchers and practitioners should join together to ensure that the research available on psychological practice is both clinically relevant and internally valid. It is important not to assume that interventions that have not yet been studied in controlled trials are ineffective. However, widely used psychological practices as well as innovations

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[1] An expanded discussion of the issues raised in this policy statement including the rationale and references supporting it may be found in the Report of the Presidential Task Force on Evidence-Based Practice available online at http://www.apa.org/practice/ebpreport.pdf.

[2] To be consistent with discussions of evidence-based practice in other areas of health care, we use the term *patient* to refer to the child, adolescent, adult, older adult, couple, family, group, organization, community, or other populations receiving psychological services. However, we recognize that in many situations there are important and valid reasons for using such terms as *client, consumer* or *person* in place of *patient* to describe the recipients of services.

developed in the field or laboratory should be rigorously evaluated and barriers to conducting this research should be identified and addressed.

Clinical Expertise

Psychologists' clinical expertise encompasses a number of competencies that promote positive therapeutic outcomes. These competencies include a) conducting assessments and developing diagnostic judgments, systematic case formulations, and treatment plans; b) making clinical decisions, implementing treatments, and monitoring patient progress; c) possessing and using interpersonal expertise, including the formation of therapeutic alliances; d) continuing to self-reflect and acquire professional skills; e) evaluating and using research evidence in both basic and applied psychological science; f) understanding the influence of individual, cultural, and contextual differences on treatment; g) seeking available resources (e.g., consultation, adjunctive or alternative services) as needed; and h) having a cogent rationale for clinical strategies. Expertise develops from clinical and scientific training, theoretical understanding, experience, self-reflection, knowledge of current research, and continuing education and training.

Clinical expertise is used to integrate the best research evidence with clinical data (e.g., information about the patient obtained over the course of treatment) in the context of the patient's characteristics and preferences to deliver services that have a high probability of achieving the goals of treatment. Integral to clinical expertise is an awareness of the limits of one's knowledge and skills and attention to the heuristics and biases—both cognitive and affective—that can affect clinical judgment. Moreover, psychologists understand how their own characteristics, values, and context interact with those of the patient.

Patients' Characteristics, Values, and Context

Psychological services are most effective when responsive to the patient's specific problems, strengths, personality, sociocultural context, and preferences. Many patient characteristics, such as functional status, readiness to change, and level of social support, are known to be related to therapeutic outcomes. Other important patient characteristics to consider in forming and maintaining a treatment relationship and in implementing specific interventions include a) variations in presenting problems or disorders, etiology, concurrent symptoms or syndromes, and behavior; b) chronological age, developmental status, developmental history, and life stage; c) sociocultural and familial factors (e.g., gender, gender identity, ethnicity, race, social class, religion, disability status, family structure, and sexual orientation); d) environmental context (e.g., institutional racism, health care disparities) and stressors (e.g., unemployment, major life events); and e) personal preferences, values, and preferences related to treatment (e.g., goals, beliefs, worldviews, and treatment expectations). Some effective treatments involve interventions directed toward others in the patient's environment, such as parents, teachers, and caregivers. A central goal of EBPP is to maximize patient choice among effective alternative interventions.

Clinical Implications

Clinical decisions should be made in collaboration with the patient, based on the best clinically relevant evidence, and with consideration for the probable costs, benefits, and available resources and options.[3] It is the treating psychologist who makes the ultimate judgment regarding a particular intervention or treatment plan. The involvement of an active, informed patient is generally crucial to the success of psychological services. Treatment decisions should never be made by untrained persons unfamiliar with the specifics of the case.

The treating psychologist determines the applicability of research conclusions to a particular patient. Individual patients may require decisions and interventions not directly addressed by the available research. The application of research evidence to a given patient always involves probabilistic inferences. Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential to EBPP.

APA encourages the development of health care policies that reflect this view of evidence-based psychological practice.

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[3]
 For some patients (e.g., children and youth), the referral, choice of therapist and treatment, and decision to end treatment are most often made by others (e.g., parents) rather than by the individual who is the target of treatment. This means that the integration of evidence and practice in such cases is likely to involve information sharing and decision-making in concert with others.

Source: http://www2.apa.org/practice/ebpstatement.pdf