# Northeast Florida Children's Community Mental Health Assessment

**A COMMUNITY-WIDE ASSETS AND NEEDS ASSESSMENT OF CHILDREN'S MENTAL HEALTH SERVICES IN NORTHEAST FLORIDA**

March 2006

# Children's Community Mental Health Assessment

Prepared by:

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Managed Access to Child Health, Inc.
Department of Pediatrics / University of Florida

In collaboration with:

The Institute for Health, Policy and Evaluation Research,
Duval County Health Department

Chaired by:

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This Assets and Needs Assessment is the result of a generous commitment of time and expertise by community stakeholders in children's mental health. Task Force members include representation from most public and private mental health agencies and child serving organizations in Northeast Florida (see Appendix A).

DCHD DUVAL COUNTY HEALTH DEPARTMENT

UNIVERSITY OF FLORIDA

cms network Children's Medical Services

MENTAL HEALTH ASSOCIATION OF NORTHEAST FLORIDA, INC.

Managed Access to Child Health, Inc.

## Introduction

In March of 2005, a group of mental health providers in Duval County convened to develop a blueprint for a comprehensive system of mental health services for children in Duval County, including low income and uninsured children and children insured by Medicaid. (See Appendix A) No recent community assessments were available to inform or guide this endeavor. This first phase of the effort focused on data gathering (Assessment). The following report summarizes the findings of the Task Force. Subsequent efforts will involve: a) further identifying gaps in services, b) structuring a system architecture, c) identifying resources required to fill the gaps in services, d) engaging and integrating providers into the system, and e) ongoing QI/QA and external evaluations of the system. In addition, we as a community need to address potential issues that result from implementation of Medicaid reform.

## Problem

According to the Surgeon General's report on Mental Health, 20% of children and adolescents experience the signs and symptoms of a mental health disorder during the course of a year (DHHS, 1999). The report also stated that there has been an ongoing misconception that "mental health" or "mental illness" is unrelated to "physical health" or "physical illness."

The existing mental health system in Florida is being challenged by internal and external stressors. Historically, District 4 has been below the state average in funding for mental health services. Jacksonville, as well as a number of other counties in the state, is targeted for "experimentation" under Medicaid reform. The mandate for reform will restructure the system without a precedent on which to build. The future role of community mental health providers is unclear. Mental health and safety net providers and mental health advocates have formed working groups to collaborate to establish plans to address the mental health needs of residents in northeast Florida. This Task Force will help to inform their efforts, as well as establish a tangible framework for a system of mental health care for children.

## Structure of Group

A Children's Mental Health Task Force, composed of community stakeholders in children's mental health services, was established to develop a blueprint for a system of care in Jacksonville to serve all children, and to begin to establish public policies that will be used as a framework to support the development of such a system. The Task Force includes consumers, psychiatrists, pediatricians, administrators, social workers, psychologists and researchers representing 32 agencies.

A smaller Working Group has been meeting monthly since March 2005. Each meeting has included discussions about a system of care in the context of prevention, diagnosis, referral and treatment. These components were considered individually, though it was understood they are relatively arbitrary divisions of a system, and that clear boundaries do not necessarily divide these system functions. Agencies, organizations, providers, etc. linked to these efforts in Jacksonville were identified to generate a "blueprint" of the current children's mental health care system in Northeast Florida. The mapping process revealed existing elements of the system, as well as gaps in services .

## Methods and Processes

A mixed method research methodology, e.g., qualitative and quantitative methods, was used for data collection and analysis. Qualitative data collection involved an open ended questionnaire. Quantitative data collection used data from closed ended surveys.

Initial data collection explored: a) the needs of local children for mental health services, b) the types of services that are provided to children with mental health illness in Jacksonville, c) collaboration between agencies, d) barriers within the mental health system, e) successes of the system, f) suggestions for how children's mental health services can be improved, and g) views about the future. An open ended questionnaire was initially administered to fourteen children's mental health stakeholders. The themes that emerged from the interview data were presented to the Working Group for validation and use in their subsequent process tasks.

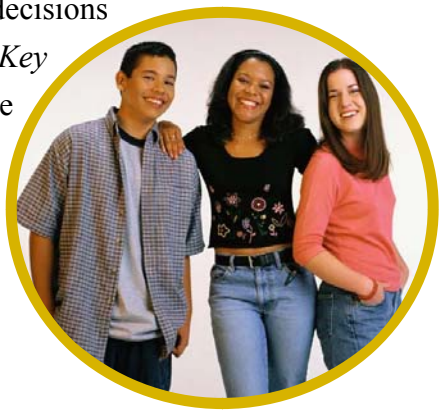
Quantitative data collection assessed the distribution of services by service type and the geographic distribution of services. The themes that emerged from the initial interviews were subsequently used in a survey to collect data from a wider audience of mental health stakeholders in the community. The main purpose of the survey was to validate the themes identified from the interviews, as well as to validate the system of care identified during the Working Group meetings.

A literature review was then completed to identify best practices for each of the service components of the mental health system. The literature reviews focused on assessment, diagnosis, treatment, care coordination and rehabilitation and habilitation. The information derived from the reviews will be used to inform the development of the system architecture.

Each step in data collection guided and informed the next. The Working Group began by: a) identifying the key stakeholders and providers for mental health services in the community, and b) developing the questions that were to be posed in the interviews. The Working Group also provided insight into the structure and function of the current system of mental health services. Following the conclusion of the key informant interviews, a survey was created based on the results from the interviews. The literature review identified what others in the mental health field have found beneficial and described existing barriers. This report also contains a case study of the response to the challenges of children's mental health from the North Carolina Advocacy Effort. Appendix B outlines the challenges, barriers, successes and results of their efforts.

## Results

The results of this initial study are presented below. The first section, *Establishing a Framework*, presents the Working Group's first decisions related to defining the stakeholders and elements of the system. The *Key Informant* section presents data from interviews of those who were identified by the Working Group as critical stakeholders in the system. After key informants identified the critical challenges facing the system, a survey was conducted to prioritize the issues of providers. This data is presented in the *Survey* section.



The sections that follow the survey section relate to the *Components* of the system. The components of the system are divided into *Assessment and Diagnosis, Treatment and Care Coordination, and Rehabilitation.* Each of these components is assessed by asking the following three questions:

- Who are the providers working in this area?
- What is known from the literature about this area of the mental health system?
- What are the perspectives of key informants related to the assets and barriers related to this component of the system?

Recommendations and Conclusions follow the Results section.

**Establishing a Framework**

The Working Group's initial tasks were to identify the stakeholders in the system and the system's components.

*Stakeholders.* The Working Group identified a broad range of stakeholders in children's mental health and mental health services. The stakeholders include, but aren't limited to: parents, caregivers, foster parents, school-teachers, child care providers, physicians, youth organizations, churches, the criminal justice system, the sheriff or police department, the insurance industry, people living or working in homeless shelters, the military, hospitals, emergency rooms, businesses, chambers of commerce and employee assistance programs. These stakeholders must be considered and integrated into any system of care that will meet the needs of all children.

*Components.* The components of the system were categorized as Prevention, Intervention and Rehabilitation. Prevention includes community education, early screening and identification, referrals and care coordination. Intervention includes assessment and diagnosis, treatment, habilitation, and care coordination. Long-term rehabilitation includes substance abuse and other types of after-care, primarily based in the community. The role of the stakeholders, the system components and access points to services are detailed in Appendix B. Figures 1-4 illustrate the location of providers and agencies who identify and diagnose, treat, provide care coordination and rehabilitate children with mental health issues in Northeast Florida (not all providers addresses were available).

**Assessment and Diagnosis Providers (Figure 2)**

Pediatric Associates of Jacksonville
UF Family Medicine
UF Pediatric Residency Program
St. Vincent family Medicine
Carithers Pediatrics
Weiss Pediatric
Mental Health Association
Family Practice Center
Pediatric Associates of Jacksonville
Andrew Robinson Pediatric Ctr.
Department of Juvenile Justice
PSI Family Services
Commission on Serv. For CSHCN
Department of Pediatrics
Jacksonville Youth Sanctuary
Triad Counseling Inc,.
Center for Women and Children
FDLRS
Bloomfield Psychological Services
Sheriff's Office
Child Guidance Ctr: Andrew Jackson High School
Child Guidance Ctr: S.P.Livingston Elementary
Child Guidance Ctr: Paxon Middle School
Child Guidance Ctr: Holiday Hills Elementary
Child Guidance Ctr: Dupont Middle School
Child Guidance Ctr: First Coast High School
Child Guidance Ctr: Terry Parker High School
Project Reach Resource Ctr: Ribault
Child Guidance
Child Guidance Executive Director
CMS/ University of Florida Department of Health
Even Start
Family counseling services
Healthy Families
Healthy Start Program Director
Hope Haven Children's Hospital
Jacksonville Children's Commission
Jewish Family and Community Services
Medical Home for Homeless Children
Mental Health Resources Center
Nemours Children's Clinic
Northwest Behavioral Health Services
Shands Jacksonville Community Relations
Youth Crisis Center

**Treatment and Care Coordination Providers (Figure 3)**

Andrew Robinson Pediatric Ctr.
Angelwood
ARC of Jacksonville
Baptist Health Regency
Bloomfield Psychological Ser vices
Carithers Pediatrics
Child Guidance
Child Guidance Ctr: Andrew Jackson High Sch
Child Guidance Ctr: Dupont Middle School
Child Guidance Ctr: First Coast High School
Child Guidance Ctr: Paxon Middle School
Child Guidance Ctr: S.P. Livingston Elementary
Child Guiodance Ctr: Holiday Hills Elementary
Child Guidance Ctr: Terry Parker High School
Commission on Services For CSHCN
Daniel
DCF-Substance Abuse Mental Health
Early Steps
Family Practice Center
FDLRS
Full Service School: Beaches Resource Center
FSS: Englewood Family Resource Ctr.
FSS: Greater Springfield Family Resource Ctr.
FSS: Ribault Family Resource Center
FSS: Ribault Family Resource Center
FSS: Westside Family Resource Ctr.
FSS: Arlington Family Resource Center Gateway
Healthy Start Program Director
Hope Haven Children's Hospital
Jacksonville Children's Commission
Jacksonville Youth Sanctuary
Jericho
Jewish Family and Community Services
Medical Home for Homeless Children
Mental Health Association
Mental Health Resources Center
Neighborhood Resource Ctr: Paxon HS
Nemours Children's Clinic
Northwest Behavioral Health Services
Pediatric Associates of Jacksonville
Pediatric Associates of Jacksonville
Project Reach Resource Center: Ribault
JPSI Family Services
St. Vincent Family Medicine
Ten Broeck
The Bridge
UF Department of Pediatrics
UF Family Medicine
UF Pediatric Residency Program
United Way / 211
Weiss Pediatric
Wolfson's Children's Hospital
Youth Crisis Center

**Rehabilitation Providers (Figure 4)**

Baptist Health Regency
Daniel
Gateway
Ten Broeck

**Figure 1.**

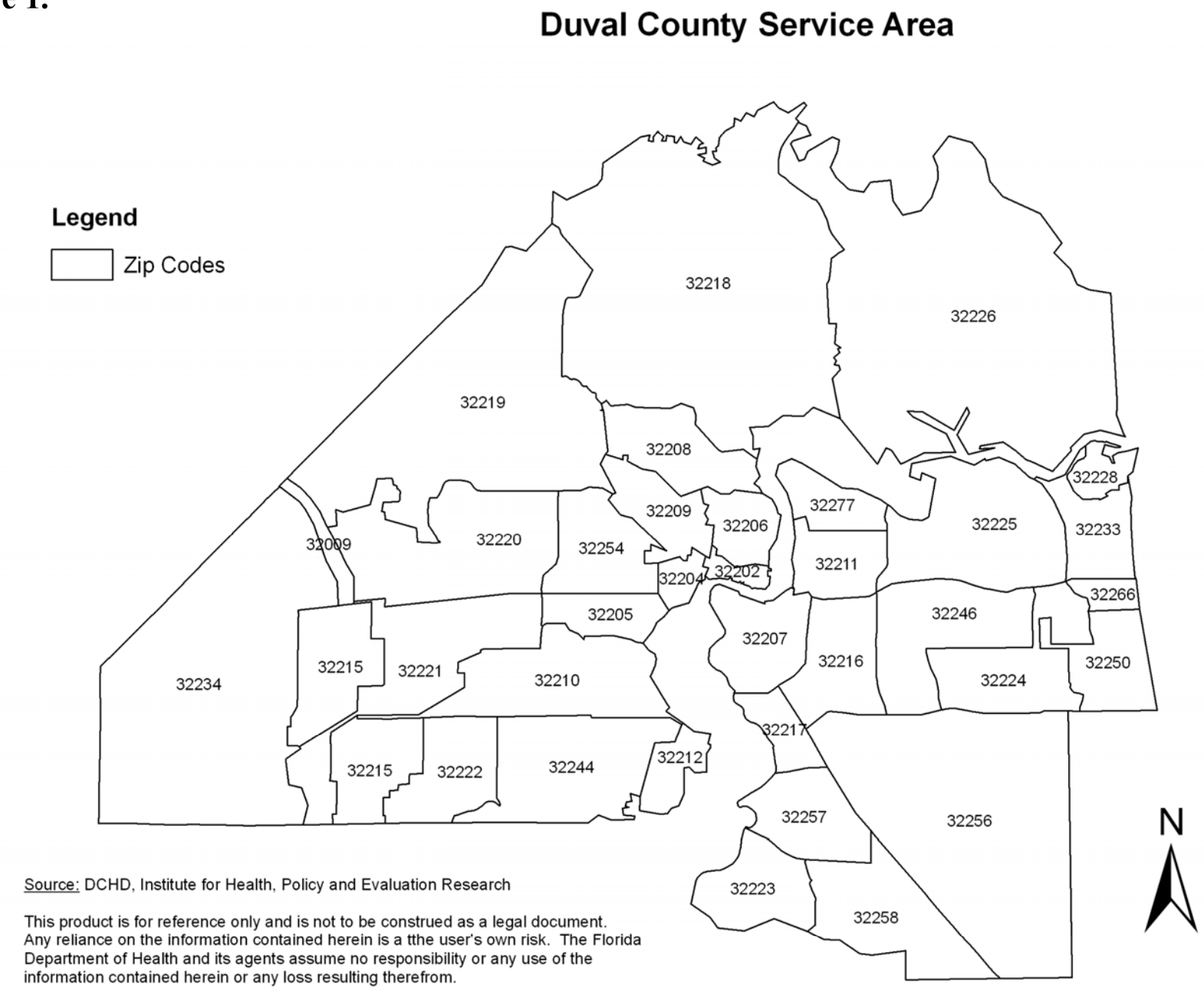

Duval County Service Area
Legend
Zip Codes
32218
32226
32219
32208
32228
32209
32277
32206
32225
32233
32009
32220
32254
32211
32204
32202
32266
32205
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**Figure 2.**

## Providers and Agencies Involved in Assessment and Diagnosis

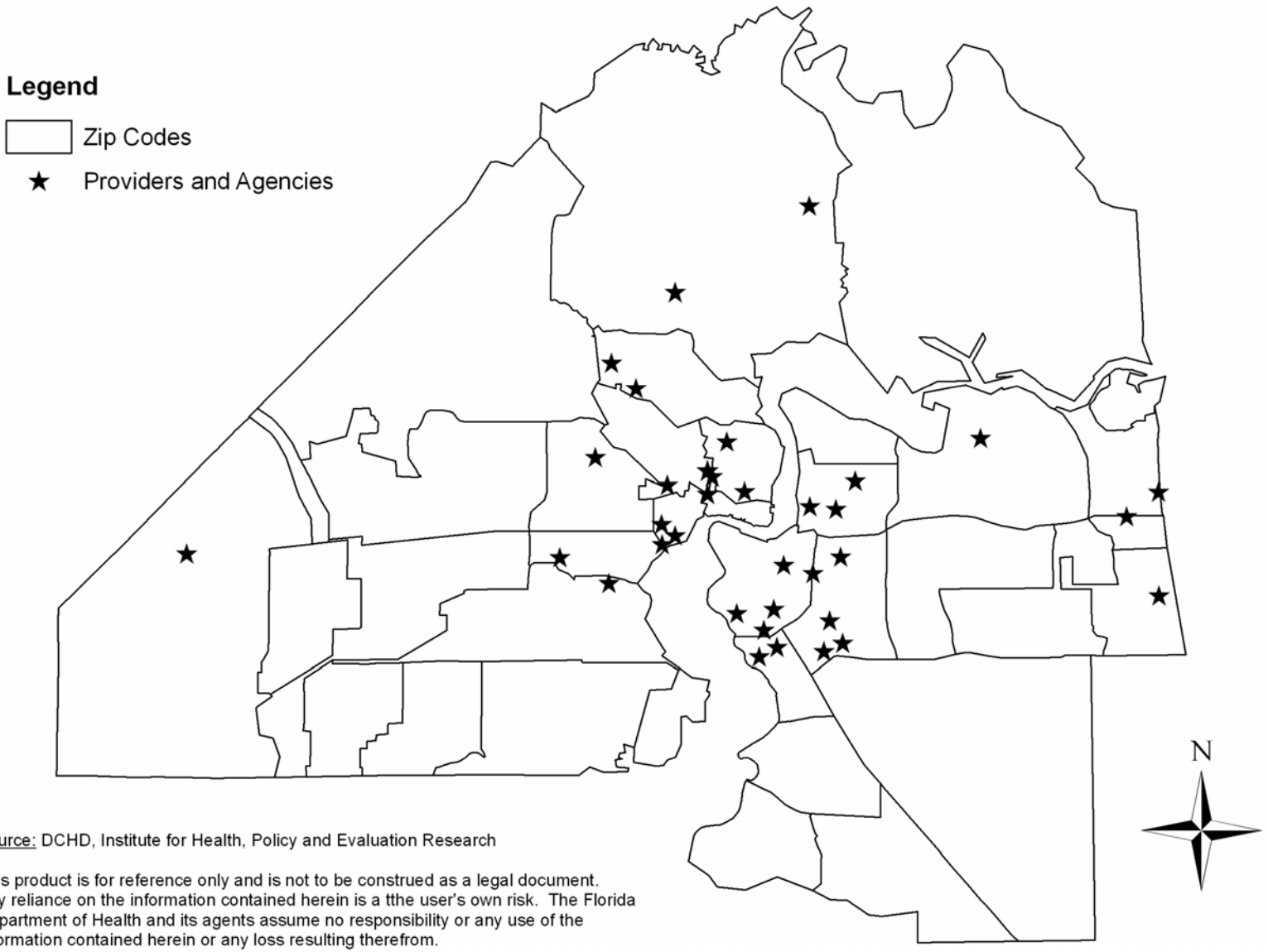


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**Figure 3.**

## Providers and Agencies Involved in Treatment and Care Coordination

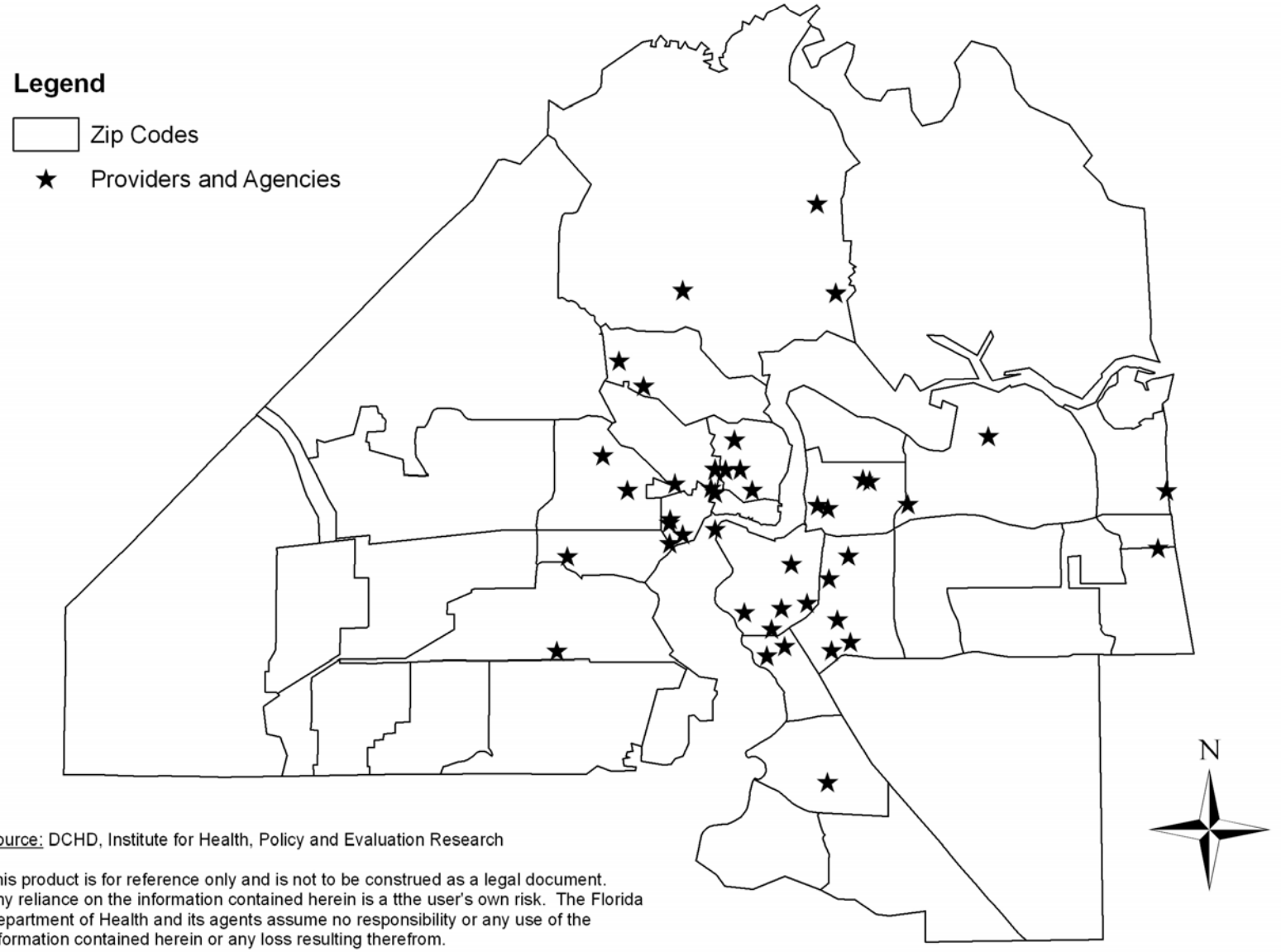


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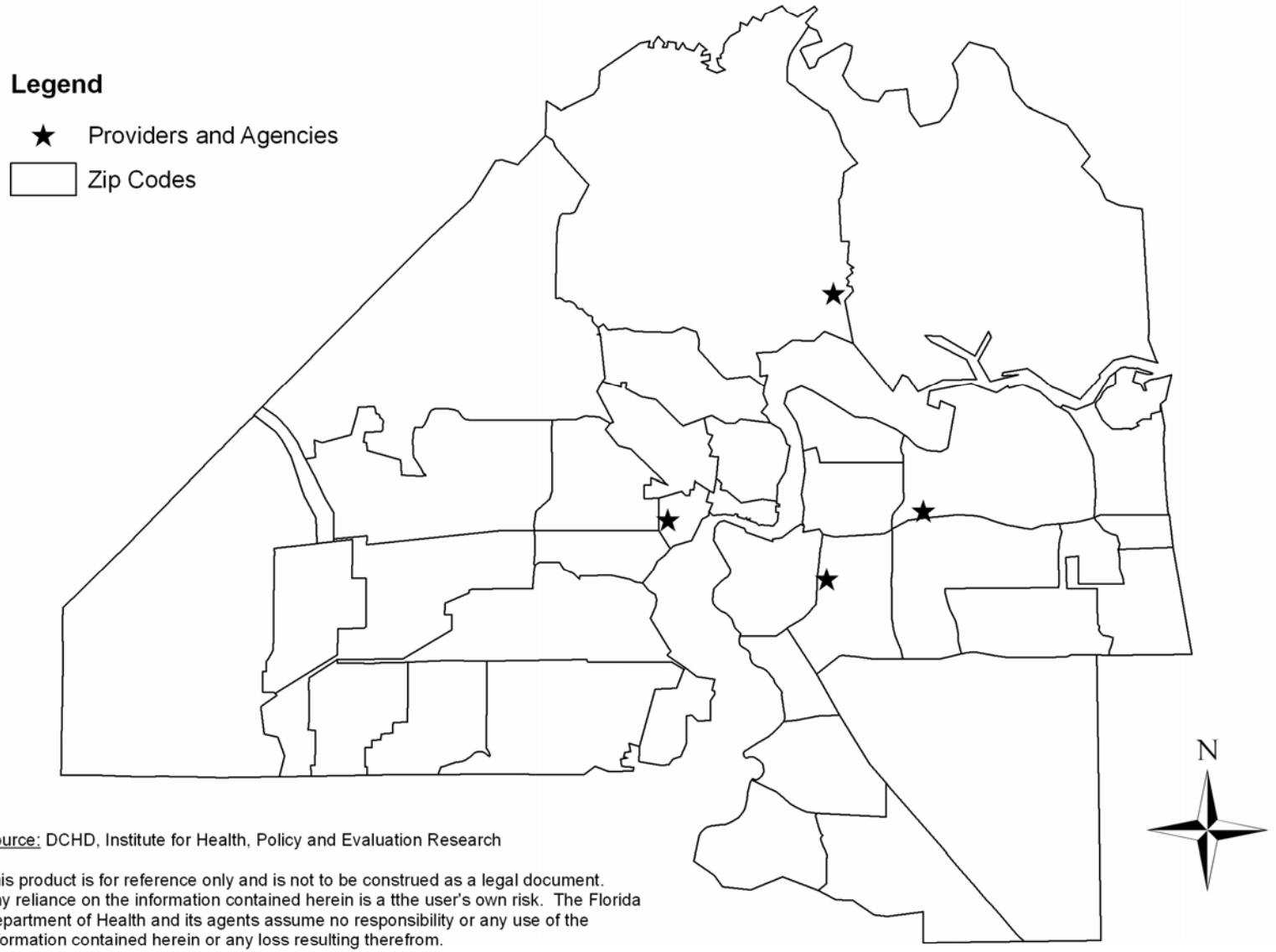
**Figure 4.**

## Providers and Agencies Involved in Rehabilitation




Source: DCHD, Institute for Health, Policy and Evaluation Research

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## Key Informant Interviews

Key informant interviews were conducted to define the critical issues impacting the mental health system for children in Jacksonville. The results from the key informant interviews were analyzed using qualitative analysis techniques. The main themes that emerged from the data are presented in Table 1. These are not in order of priority. Key informant interview responses are also presented in the section of Assessment and Diagnosis, Treatment and Care Coordination, and Rehabilitation.

**Table 1**
**Emergent Themes**
**Key Informant Interviews**

1. Access: There is a lack of qualified mental health professionals.
2. Lack of services: Jacksonville has an overburdened system and is not seeing enough children.
3. Parental involvement: Parents should be involved in a child's mental health plan.
4. Medicaid: Barriers for children on Medicaid include: poor reimbursement rates for services and that there is only limited access to PhD level mental health professionals.
5. Coordination: There is a problem with coordination. The important link between primary care physicians and mental health providers is not present.
6. Schools: Mental health programs are working well in the school system.
7. Transiency: Transient populations of children. Children and families are moving frequently. Substantial numbers of children change schools each year.
8. Funding: Funding reimbursement rates are low under Medicaid.
9. Clinical care: Children are not receiving appropriate medication, treatment and diagnosis.
10. Duplication: There is duplication and competition among different providers of mental health services.
11. Access: Access to care issues relate to transportation, hours of operation of clinics, etc.

## Survey of Stakeholders

Based on the results of the key informant interviews, a survey of providers was conducted to attempt to "quantify" the importance of the issues identified by the key informants. Table 2 presents the list of providers who ultimately completed the survey. There was a 30% response rate to the survey. Table 3 presents their ranking of emergent themes.

| Table 2<br>Agencies and Organizations Responding the Survey | |
|---|---|
| Ten Broeck Hospital | Department of Juvenile Justice |
| Jacksonville Sheriff's Office | Youth Crisis Center |
| TRIAD Counseling Inc. | Child Guidance Center |
| Duval County Public Schools ESE | NE FL Healthy Start Coalition |
| Full Service Schools- United Way of NE FL | Bloomfield Psychiatric Services |
| World Good News Inc. DBA | PSI Family Services |
| Jacksonville Youth Sanctuary | Hope Haven |
| Department of Children and Families (DCF) | Medical Home for Homeless Children |
| DCF/Substance Abuse Mental Health | Nemours Children's Clinic / Wolfson Children's Hospital |

**Table 3**
**Themes Related to Provision of Children's Mental Health Services in Jacksonville - Based on a scale of 1 (least important) - 5 (most important)**

| Themes | Average Ranking |
|---|---|
| 1. Barriers for children on Medicaid | 4.53 |
| 2. Lack of services: not seeing enough children and an overburdened system | 4.24 |
| 3. Funding: reimbursement rates are low under Medicaid | 4.06 |
| 4. Lack of parental involvement in child's mental health plan | 3.82 |
| 5. Effects of children changing schools frequently | 3.65 |
| 6. Medication, treatment and diagnosis | 3.59 |
| 7. Access to care: transportation, hours of operation of clinics | 3.59 |
| 8. Link between primary care providers and mental health providers | 3.50 |
| 9. Mental health programs in the school system | 3.47 |
| 10. Lack of qualified mental health professionals | 3.06 |
| 11. Service delivery: duplication and competition among different providers of mental health services | 2.94 |

**Examining the System Components**

As previously noted, the mental health system was conceptualized by the Working Group as being composed of several components: *Assessment and Diagnosis, Treatment and Care Coordination, and Rehabilitation*. Each of these components was assessed by analyzing the following three questions.

- Who are the providers working in this area?
- What is known from the literature about this area of the mental health system?
- What are the perspectives of key informants related to the assets and barriers related to this component of the system?

### *Assessment and Diagnosis*

The providers identified as participating in this component of the mental health system are presented in Table 4.

**Table 4**
**Providers Involved in Assessment and Diagnosis**

| | |
|---|---|
| Pediatrician / Family Practice / Health Providers | Even Start |
| Child Guidance Center | Family Counseling Services |
| Northwest Behavioral | FDLRS |
| Mental Health Resources Center | Healthy Families |
| Shands | Healthy Start |
| Nemours | Homeless Shelters |
| Hope Haven | Hubbard House |
| Private Practice | Jacksonville Children's Commission Programs |
| Psychologists | Jewish Family and Community Services |
| Social Workers | Juvenile Dependency |
| EAP | Juvenile Justice |
| Developmental - Dr. Childers & Dr. Belsito | Schools - ESE |
| Early Learning Centers / Preschools | The Bridge |
| Early Steps | Youth Crisis Center |

The literature review related to *Assessment and Diagnosis* is presented in Table 5.

**Table 5**
**Literature Review**
**Assessment and Diagnosis**

1. Need to identify, correct, or at least minimize problems as early after their onset as feasible. (Rutgers, 2002)
2. Consider annual screening of adolescents. (Rutgers, 2002)
3. Need to consider assessment of mental health problems in the primary care setting. (President's New Freedom Commission on Mental Health, 2003)
4. It is optimal to link assessment and diagnosis with treatment. This will help prevent mental health problems from becoming worse. (President's New Freedom Commission on Mental Health, 2003)
5. Screening and early intervention will occur if both are readily accessible, in particular if they are available in low stigma settings such as: primary care facilities and schools, as well as where high risk exists for mental health problems: criminal justice, juvenile justice and child welfare systems. (President's New Freedom Commission on Mental Health, 2003)
6. Prevention is key. (President's New Freedom Commission on Mental Health, 2003)
7. Make sure assessment and diagnosis processes are culturally relevant. (President's New Freedom Commission on Mental Health, 2003)
8. It is important to incorporate evaluation of service effectiveness and consumer satisfaction. (President's New Freedom Commission on Mental Health, 2003)

**Table 5**
**Literature Review**
**Assessment and Diagnosis cont...**

9. Primary care doctors' offices and schools are important settings for the potential recognition of mental health disorders in children and adolescents, yet trained staff is limited, as are options for referral to specialty care. (DHHS, 1999)
10. Access to care is a concern in rural and underserved areas. (President's New Freedom Commission on Mental Health, 2003)
13. Accessibility of services is not ideal. (President's New Freedom Commission on Mental Health, 2003)
14. Affordability of services is a major problem. (President's New Freedom Commission on Mental Health, 2003)
15. Need to Coordinate services in one Medicaid system. (President's New Freedom Commission on Mental Health, 2003)
16. Choice of health care services and resources is limited. (President's New Freedom Commission on Mental Health, 2003)
17. Certain Medicaid related services and options are not used as effectively as they should be.
    - Early and periodic screening, diagnosis and treatment (EPSDT) is one of the services through Medicaid that is under-utilized.
    - The EPSDT mandate requires states to screen, diagnose and treat all Medicaid eligible children for physical and mental illnesses. States are supposed to report EPSDT performance information annually via a CMS form, but not all do. In fact, many states do not give providers the information necessary to facilitate available services. Data shows that of 22.9 million eligible children, only 37 percent received a medical screen
    - Requiring stricter adherence by providers to the mandate may increase screening. (NGA, 2005)
18. Medicaid offers low reimbursement rates for office visits.
19. Medicaid reimburses only for a definitive diagnosis.
20. There is a lack of reimbursement for non-face to face aspects of delivering behavioral health services.
21. Reimbursement rates are generally for mental health providers- reimbursement for the delivery of mental health services by primary care physicians is limited.

Key informants identified the following related to *Assessment and Diagnosis* of mental health disorders.

**Table 6**
**Key Informant Perspectives**
**Related to Assessment and Diagnosis**

1. Parents need to be informed enough to be able to identify issues of concern in their children as early as possible.
2. Compliance with appointments leading to successful follow through, e.g., referrals, is important.
3. It is optimal when primary care physicians and psychiatrists (specialists) collaborate to assess and diagnose a child with mental health problems, just as they would any other physical health ailments.
4. Locate services where children already are (schools, day cares, boys and girls clubs, etc.).
5. Screening by primary care physicians is important if we are to identify children with mental health disorders as early as possible.
6. The system is overburdened - there are not enough resources to see all of the children that need to be assessed and diagnosed.
7. Inconsistent providers for assessment and diagnosis

### *Treatment and Care Coordination*

This component of the system, focused on interventions, is divided into treatment and care coordination. Each is considered separately.

***Treatment***. The providers identified as participating in this component of the mental health system are presented in Table 7.

**Table 7**
**Agencies and Providers Involved with Treatment**

| | |
|---|---|
| Pediatrician / Family Practice / Health Providers | Healthy Start |
| Child Guidance Center | Homeless Shelters |
| Northwest Behavioral | Hubbard House |
| Mental Health Resources Center | Jericho |
| Nemours | Jewish Family and Community Services |
| Hope Haven | Juvenile Dependency |
| Private Practice | Juvenile Justice |
| Psychologists | Mental Health Resource Center (in-patient) |
| EAP | Ten Broeck (in-patient & residential) |
| Angelwood (residential) | The Bridge |
| CARD | Wolfson (in-patient) |
| Daniel (residential) | Youth Crisis Center |
| Developmental - Dr. Childers & Dr. Belsito | Developmental Services |
| FDLRS | Early Steps |
| Foster Care | Jail / Sherriff |
| Full Service Schools | |

The literature review related to *Treatment* is presented in Table 8.

**Table 8**
**Literature Review**
**Treatment**

1. A challenge for the nation in the near future is to speed the transfer of new evidence-based treatment and prevention interventions into diverse service delivery settings and systems, while ensuring greater coordination among these settings and systems. (DHHS, 1999)
2. There is a need to draw attention to special needs associated with a particular disorder or disability, as well as by age or gender or by the racial and cultural identity of those who have mental illness. (DHHS, 1999)
3. Treatment must include evidence-based strategies. (UCLA, 2004)
4. Important to encourage self-help and focus on recovery from mental illness. (DHHS, 1999)
5. School mental health programs must provide treatment services with full attention to the confidentiality and privacy of children and families. (UCLA, 2004)

| Table 8<br>Literature Review<br>Treatment cont... |
|---|
| 6. There is a barrier between what is optimally effective treatment and what many individuals actually receive. (DHHS, 1999)<br>7. It is not enough to just identify problems, youngsters and their support systems need to acquire knowledge, skills, and attitudes that enable them to prevent problems and deal with those that can't be avoided. (UCLA, 2004)<br>8. There is a need for the capacity to treat children with co-occurring disorders. (UCLA, 2004)<br>9. Only 19% of people who have co-occurring serious mental illnesses and substance dependence disorders are treated for both disorders. 29% are not treated neither. (UCLA, 2004)<br>10. When mental illnesses are identified, they are not always adequately treated in the primary care setting, and referrals from primary care to specialty mental health services are often never completed. (UCLA, 2004)<br>11. Primary Care Providers (PCPs) may make referrals for treatment, however, significant barriers exist, including lack of available specialists, insurance restrictions, appointment delays, and stigmas. (UCLA, 2004)<br>12. In one study, 59% of youth who were referred to specialty mental health care never made it to a specialist. (UCLA, 2004)<br>13. Medical providers often have difficulty providing adequate medical care to consumers with co-existing mental and physical illnesses. It is important for all systems involved to work together. (UCLA, 2004)<br>14. PCPs frequently experience pressure to prescribe medications and deliver services for which they are inadequately trained. (Meschan Foy, et. al, 2002) |

Key informants identified the following related to *Treatment* of Mental Health Disorders.

| Table 9<br>Key Informant Perspectives<br>Related to Treatment |
|---|
| 1. Medication plans that are linked to a behavior plan implemented by a licensed, school therapist are optimal.<br>2. There is not enough medium level mental health treatment available for children. Most available treatment is for the most extreme cases.<br>3. There is a lack of qualified personnel, the system needs incentives to attract and retain qualified personnel and there is limited reimbursement from Medicaid for Ph.D. psychologists.<br>4. If families are not able to afford the basic necessities of life, they will not be able to comply with their mental health needs and those of their children. The child suffers, which leads to truancy at school and perhaps depression, both of which result in school problems. It is a continuous cycle.<br>5. More PCPs need to be trained and feel more comfortable identifying mental health needs and prescribing medications. There is a lack of training and comfort among physicians in the area of mental health.<br>6. Therapeutic services are not well funded under Medicaid, only treatment.<br>7. Parents need to have a detailed understanding of why their children are being referred. |

***Care Coordination***. The providers identified as participating in this component of the mental health system are presented in Table 10 .

**Table 10**
**Agencies and Provider Involved with Care Coordination**

| | |
|---|---|
| Child Guidance Center | Foster Care |
| Mental Health Resources Center | Full Service Schools |
| Northwest Behavioral | Gateway |
| CARD | Homeless Shelters |
| Daniel (residential) | Hubbard House |
| Developmental Services | Jacksonville Children's Commission Programs |
| Early Steps | Jericho |

The literature review related to *Care Coordination* is presented in Table 11.

**Table 11**
**Literature Review**
**Care Coordination**

1. Programs must be comprehensive, flexible, and responsive to the needs of participants. (Rutgers, 2002)
2. Programs that link with other systems of support and intervention to ensure they can produce and sustain their impacts over time are optimal. (Rutgers, 2002)
3. Programs should develop plans of care that are customized and in full partnership with consumers. (President's New Freedom Commission on Mental Health, 2003)
4. Programs should give patients opportunities to network with other consumers and families in care. (President's New Freedom Commission on Mental Health, 2003)
5. Following the Medical Home Model, care must be accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective. (Georgetown University, 2004)
6. There is a lack of a full continuum of high-quality services that are available locally, and that are sufficient to meet the needs of all children with special needs. Funders should focus funding for direct services and training to fill gaps, improve quality, and expand the number of children with special needs who are served. (JCCI, 1997)
7. There is a lack of coordinated efforts among service providers to ensure efficiency and effectiveness throughout the system of service delivery for children with special needs. The Human Services Council should take the lead, working with existing coordinating groups to establish an overall coordinating body to focus attention, advocacy, information gathering and sharing and service improvement efforts on behalf of children with special needs. (JCCI, 1997)
8. Ideally a child would rely on a single case manager, however, because of the multiplicity of case managers in different agencies, children with multiple disabilities or disorders may have multiple case managers. (JCCI, 1997)
9. Poor coordination and poor integration of mental health services with children's pediatric care further diminish accessibility and quality of the care that is provided in both public and private sectors. (Meschan Foy, et. al, 2002)

Key informants identified the following related to care coordination for patients (Table 12).

**Table 12**
**Key Informant Perspectives**
**Related to Care Coordination**

1. We need play therapy training for families.
2. Families that work with a case worker will succeed.
3. Follow through has to be consistent.
4. There is a lack of care management for children with mental health issues. A multidisciplinary team should decide the level of services a child is going to receive.
5. Too many agencies provide similar services (Recommendation: agencies should share administrative costs, unify, and use the money they save to improve services)
6. There is a fragmentation in care among different institutions.
7. It is hard to reach people where they are - Jacksonville is so spread out. (Recommendation: some agencies are spreading out their staff and have found the process less efficient but effective.)
8. If a family cannot afford basic necessities in life, they will find it hard to comply with their child's

***Rehabilitation***

This component of the system focuses on the rehabilitation of children who have been diagnosed and treated for mental illnesses. Little is found in the literature about this component . Table 13 lists the providers of *Rehabilitation* services in Jacksonville.

**Table 13**
**Agencies and Provider Involved with Rehabilitation**

1. Daniel (residential): Long Term Residential
2. Ten Broeck (in-patient & residential): Long Term Residential
3. Therapeutic Foster Care (Boys' Home & Children's Home Society): Long Term Residential
4. Private Practice: Rehabilitation for Substance Abuse
5. Gateway: Rehabilitation for Substance Abuse

Additional comments were received from members of the working group during the monthly meetings.

1. There is a lack of continuity of care for foster children. These children need case managers that are medically qualified.
2. Long term and residential treatment facilities should be linked with community and public mental health providers. There is a lack of these services.
3. There are more access points that make referrals than take referrals.

## Conclusions

The findings of this study are clear. We have an inadequate and fractured system of care in Jacksonville that cannot adequately respond to the mental health needs of our children. At any given time, one in every five young people is suffering from a mental health problem. Two-thirds are not getting the help they need. The consequences of not responding to this crisis are cumulative and impact virtually all aspects of the health and well-being of our children and our communities. Failing to respond to the realities faced by so many of our children and families ignores the growing evidence base for the long term consequences of mental health issues in children, their impact on adult health, and our capacity to intervene to prevent and treat them. Other locales, in particular North Carolina, have mobilized to improve their response to this critical health problem, and so can we.

Within the limits of this initial assessment, we identified numerous committed public and private sector providers, but little evidence of a system that links them together into a coherent system and tangible network. Elements of the system are extensive and are listed throughout this report. However, they generally operate independently of one another and there is limited communication among providers. Marginalized children with mental health problems, e.g., homeless, foster care, refugee, immigrant, incarcerated, low income, Medicaid-insured children, etc. are at greatest risk for not receiving required mental health services.

Though the system is fractured and insufficient resources are available to meet the current and future needs of children, assets do exist to begin the development of a system of care for children's mental health. The following recommendations are built on the evidence-base presented in this report. They are not exhaustive, but reflect the work and priorities of the Task Force. The intent of this endeavor has been to develop a consensus on the state of, and challenges to the system of care for children's mental health services in Northeast Florida.

## Recommendations

The following recommendations are based on the findings of the working group and reflect key issues that need to be addressed. They are not listed in any order of priority.

1. *Initiate a sustained and focused endeavor to build a functioning mental health system for children in Jacksonville.* Subsequent efforts will need to involve: a) identifying gaps in services, b) structuring a system architecture, c) identifying resources required to fill the gaps, d) engaging and integrating providers into the system, and e) ongoing QI. This initial assessment is the first step. Subsequent steps in this endeavor could begin with an assessment of and intervention in the mental health system for children in foster care. The support of key stakeholders and funding must be obtained to continue the work of this Task Force.

2. *The community should work to:*

- *Increase funding for children's mental health services from all funders, including local and state government, insurers, and other community based sources,*
- *Advocate with the Legislature for equity in funding for children's mental health services for District 4,*
- *Advocate for adequate funding and services to meet the individual needs of each child,*
- *Increase local and state funding for primary and secondary prevention and efforts to promote mental health and social emotional wellness, and*
- *Change Medicaid regulations so that agencies can be reimbursed for certain "V" codes such as Relational Problems and Problems Related to Abuse and Neglect.*

There is inadequate funding for children's mental health services. Florida ranks 48 out of the 50 states. Compared with other parts of the state, District 4 does not receive an equitable share of state funding for children's mental health services. Mental health services are not funded at the same level as physical health services. Funding is tied to specific services, is highly dependent on the differentiation between "behavioral issues" and "psychiatric diagnosis" and is not always flexible to meet the particular needs of a child or family. Changes in funding related to Medicaid reform will further challenge the system.

3. *A data collection system should be established to identify and monitor mental health services for children and the extent of unmet need.* We have a continuum of mental health services related to prevention, intervention, and treatment and rehabilitative services, but it is unclear of the extent of the unmet need for these services. Michigan has developed such a model that could be used to help develop a data system.

4. *Consideration should be given to focused efforts to deal with the following:*

- *Identifying and responding to the barriers to children for mental health services on Medicaid, that include, but aren't limited to:*
  - *Improving reimbursements for providers, and*
  - *Increasing the number of providers by expanding the breadth of professionals authorized to see children.*
- *Engaging parents in the care of their children. Lack of services to support parents in their roles jeopardizes the success of the care of their children. Parents must be full partners in the identification and treatment of their children.*
- *Identifying mental health problems in parents and treating them as a necessity if they are to have the capacity to support the care of their children.*
- *Training foster care parents in their role to address the mental health issues of the children in their care.*
- *Ensuring children enrolled in a school can stay in that school at least through the entire school year, and work to maximize the number of years students stay in a particular school.*
- *Improving access to care by identifying and responding to transportation issues negatively impacting families.*
- *Linking primary care and mental health providers.*
- *Expanding access to mental health services in schools.*

*5. Create a CEO-level Task Force that engages all entities that provide mental health services*. The Governor's Task Force on Mental Health and Substance Abuse recommended creating a county-level CEO Task Force that brings together all entities that provide mental health services to children, e.g., private and public sector health and

mental health providers, DCF, DOH, Sheriff, etc., in an effort to integrate the system, decrease duplication of services and expand services. The process of integrating the system will be incremental, but immediate efforts could include a focus on specific groups, such as the foster care population, children insured by Medicaid and children in detention, and the implementation of validated mental health screening tools, e.g., the Columbia Teen Screen.

6. *Encourage legislation that protects the judicial system from being placed in the position of making medical decisions for children in foster care, and provide it with the support it requires to function in the best interest of children*. Legislation is required to assure quality psychiatric care for foster children—legislation that facilitates foster children's access to comprehensive and complimentary mental health services. A group should be convened to consider and resolve these issues. The group should include those parties involved in this system such as: dependency judges, representatives from Child Welfare Legal Services, the Guardian Ad Litem Program, Legal Aid, mental health providers, Family Support Services, Community Based Care service providers, and medical foster care. The concerns are:

- Judges are making medical decisions on issues, such as the appropriateness of medication and passes to leave residential facilities. These decisions sometimes are in opposition to the recommendation of medical and mental health professionals.
- There are problems with communication between the mental health or medical facility and the Family Service Counselor (FSC) and judges.
- Timeliness of medication approval has been an issue, but Child Welfare Legal Services (CWLS) has attempted to expedite the necessary process to obtain a court order approving medication.

*7. There is a shortage of trained mental health providers nationally, and anecdotal evidence indicates the same is true here in Jacksonville. In response:*

- *There should be a focused endeavor to train pediatricians to identify and treat children for mental health issues within the limits of their capacities and scope of their practice.* There is a national effort to prepare pediatricians to serve the mental health needs of children.

- *Primary care physicians should be trained to coordinate their care with mental health providers during treatment and at transition points, such as referral to psychiatrists and when cases are ready for closure in the mental health system.*

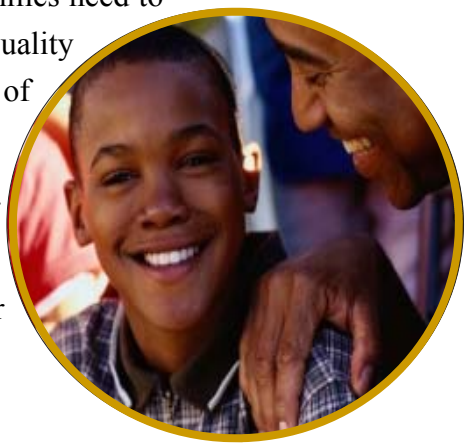
- *Mental health services must be linked to pediatric care in the context of a medical home approach to child health services.*

*8. Florida Medicaid reimbursement must be expanded to include other licensed professionals in order to expand care.* Private licensed therapists can be certified to provide and be reimbursed by Medicaid for Comprehensive Behavioral Health Assessments as long as they have an affiliated psychiatrist, but cannot be reimbursed for therapy. Only "Community Mental Health Centers" with a contract with the local Substance Abuse and Mental Health office can be reimbursed for therapy through Medicaid. This limits access to treatment.

9. *All children should be in a Medical Home to receive their primary pediatric care*. As one in five children have a mental health problem, communication about mental health services—identification, assessment, referral and treatment, must be linked back to the pediatrician (family practitioner) as happens with subspecialty medical referrals, to ensure continuity of care.

10. *Medicaid reform and its impact on mental health services should be monitored to include denial of care and the provision of adequate services*. Medicaid reform and the carve out of mental health services will negatively impact access to care and the integration of medical and mental health services.

11. *Children and families should be sensitized to the need, and trained to identify mental health problems in themselves and their children.* This should occur early in children's education and in parenting training. Patients and families need to be involved in developing the system in the future. Quality improvement of the system must also include evaluation of effectiveness.



12. *Services should be better located near populations of children who are in need.* The Full Service Schools and other similar programs need to be assessed, improved and/or expanded to include prevention and other required services.

13. *Expand screening and referral by primary care providers and other professionals (child care, Boys and Girls Clubs, juvenile justice, child welfare systems, etc.) that interact with children.* The earlier screening occurs, the sooner interventions can be implemented and the more effective they become. Annual mental health screening of adolescents should be considered. Mental health screening should also be part of EPSDT. Reimbursement must be expanded to medical providers to ensure they are involved with integrating screening into their protocols. Screening instruments must be culturally relevant.

14. *Care management should be an element of treatment protocols once mental health issues are identified and children are in treatment.* Children with mental health problems and their families are often dealing with other complex medical, social and environmental conditions. Care management is necessary to provide families with the support they need and help to navigate the health care system.

*15. Efforts should be made to integrate programs and services.* A system of care should be developed that connects agencies that provide services through a consortium or coalition that would promote coordination and cooperation in the delivery of services to children and their families, while allowing flexibility and consumer choice in the selection of service providers.

16. *Providers should be trained to ensure children and parents are identified and referred to treatment*. Relatively few children are diagnosed and treated for co-morbid mental health and substance abuse conditions.

17. *The Human Services Council should take the lead, working with existing coordinating groups to establish an overall coordinating body to integrate the system of care*. There is a precedent for the HSC in the development of systems to serve communities in Jacksonville. The Full Service School program is perhaps the best example. With the inclusion of foundations on the Human Services Council, the Council could play an important role in advancing the children's mental health system in Duval County.

18. *Moving substance abuse and mental health services from DCF to the Department of Health to support parity of service levels and payment should be considered.* To be successful, DOH should maintain long standing connections with community based non-profit organizations providing children's mental health services.

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# Appendix A

The Children's Community Mental Health Assessment Task Force was composed of representatives of the following organizations:

- Child Guidance Center
- Children's Medical Services
- Commission on Services for Children with Special Needs
- Duval County Health Department / Maternal and Child Health
- Duval County Schools / Exceptional Student Education
- Duval County Schools / Full Service Schools
- Early Steps
- Family Resource Coalition, Inc.
- Florida Department of Children and Families / Substance Abuse Program
- Hope Haven Children's Clinic and Family Center
- Jacksonville Area Legal Aid
- Jacksonville Children's Commission
- Kids N' Care
- Managed Access to Child Health, Inc
- Mental Health Association
- Nemours Children's Clinic
- Northwest Behavioral Health Services
- Pediatric Associates of Jacksonville
- Ten Broeck Hospital
- Triad Counseling
- University of Florida /Jacksonville, Department of Pediatrics
- United Way of Northeast Florida
- Youth Crisis Center

# Appendix B

## The North Carolina Advocacy Effort

### The extent of the mental health problem in North Carolina

1. Their mental health services were in disarray.
2. Medicaid's low reimbursement rate for office visits, requirement of a definitive diagnosis and lack of reimbursement for many non face-to-face aspects discouraged providers from seeing uninsured children.
3. Pediatricians felt pressured to prescribe psychiatric medications they did not feel adequately trained to prescribe.
4. Poor coordination and poor integration of MH Services with children's pediatric care diminished accessibility and quality of the care provided.
5. Reimbursement for Mental Health services was frequently allowed only to mental health providers, eliminating any financial incentive for primary care physicians to share in the care of children with mental health conditions.
6. Separate isolated training programs for mental health and medical professionals has led to separate administrative structures, separate working environments, different terminologies, different diagnostic approaches, different educational programs, and separate reimbursement codes.

### North Carolina's Assets

1. Active chapter of the American Academy of Pediatrics.
2. Five academic pediatric programs (one of the chairs of these programs was Secretary of DHHS).
3. A long history of effective collaboration with state government.
4. Introduced a non-Medicaid State Children's Health Insurance Plan that built around the State Health plan and did not increase overall costs, reduced inpatient mental health days, and provided an open dialogue among a fiscally conservative political climate.

### Objectives of the North Carolina Advocacy Effort

1. Articulate pediatricians' perspective on the current crisis in delivering and coordinating children's behavioral health services.
2. Represent the collective voice of academic and community pediatricians in dialog with mental health providers, Medicaid leaders, and the health and mental health segments of state government.
3. Build consensus about an achievable plan of action to address pediatricians' reimbursement and systems issues.
4. Develop a full and appropriate role for pediatricians as providers and potentially as coordinators of behavioral health care.
5. Facilitate implementation of Medicaid changes as a first step in carrying out this plan.

**The Process**

1. Articulated pediatricians' perspectives through a position paper.
2. Included other stakeholders to develop a consensus plan.
3. Worked with Medicaid.
4. Focused on outcomes of advocacy (i.e. changes in Medicaid for MH).
5. Educated pediatricians on the topics that were identified as most critical.
6. Continued their advocacy efforts.

**Lessons Learned about working with State Government**

1. Advocates must take advantage of political opportunities that present themselves.
2. State government administrators often view sub-specialty care, especially that which is delivered at academic centers, as exotic and expensive.
3. Personal relationships with state government leaders are at the heart of successful negotiations.
4. Advocating as a coalition with a common agenda is much more effective than smaller groups with different agendas.
5. A government official will have little sympathy for enhancing physicians' income, especially because it probably far exceeds his own.
6. Child advocates must seek out opportunities to understand the perspective of state government administrators and, when possible, to assist them with their problems.
7. Child advocates must pursue strategies that are compatible with the political and economic environment.
8. Specific Strategies most beneficial in negotiating with Medicaid will vary state to state.

**Changes in Medicaid as a result of their efforts**

1. Medicaid increased the number of visits it would reimburse for without a diagnosis.
2. Medicaid now covers up to 26 visits in a calendar year for Medicaid recipients up to age 21.
3. Medicaid now covers primary care provider referrals for up to 26 mental health visits annually for children under the age of 21.
4. Medicaid now allows physicians who employ licensed clinical social workers and clinical nurse specialists (with psychiatric certification) to bill for services if the physician provides on-site supervision.
5. Medicaid now allows health departments who employ licensed clinical social workers, licensed psychologists, and advanced practice nurses to bill for services in school-based health centers if a physician provides supervision by phone or beeper.
6. Medicaid now allows direct Medicaid enrollment from independently practicing licensed clinical social workers, licensed psychologists, and advanced practice nurses, allowing them to bill for services delivered in their offices.
7. Medicaid now allows independently enrolled mental health professionals to bill for services delivered in school sites.

**Some of the things that didn't work as a result of their efforts**

1. The group was unsuccessful in achieving Medicaid reimbursement for non face-to-face services.
2. The group was unsuccessful in achieving an enhanced fee for services performed by pediatricians with subspecialty training.
3. Mental Health programs had to compete for the 1st time for physician referrals of low income patients.
4. The growing phenomenon of split therapy (a portion of therapy provided by a non-physician without an established relationship with the professional is who expected to deliver the other portion).

Since its implementation, the advocacy initiative has made significant progress in changing the environment in which mental health services are provided to the children of North Carolina. (Meschan Foy, et.al, 2002)

# Appendix C

## Children's Mental Health Project - Stakeholders, Components and Access Points

**Objective:** to create a blueprint for a successful child mental health system in Northeast Florida.

| Stakeholders |
|---|
| · Parents/caregivers/foster parents |
| · School- teachers |
| · Child Care |
| · Ob/Gyn |
| · Physician (Family practice and pediatricians) |
| · Youth organizations |
| · Churches |
| · Criminal justice system / sheriff |
| · Insurance industry |
| · Shelters (homeless, domestic violence) |
| · Military |
| · Hospital / ER |
| · Businesses / Chamber / Wellness Councils / Employee Assistance Programs |
| · Government - City, Emergency Services, DCF, Department of Administration |

| Components | | |
|---|---|---|
| **Prevention (P)** | **Intervention** | **Rehabilitation**<br>**$R^{LT}$ = Long-Term rehab**<br>**$R^{SA}$+ Substance Abuse** |
| Community Education | Assessment / Diagnosis (A/D) | Follow-up |
| Early Screening / Identification of Risk factors | Receive Referrals (RR) | After-care |
| Referral | Treatment - Individual / Family Therapy (T) | |
| Care Coordination | Habilitation (H) | |
| | Care Coordination (CC) | |
| | Make Referrals (MR) | |

| Access Points | Service provided | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Prevention | Assessment/Dx | Reveive Referrals | Treatment | Habilitation | Care Coordination | Make Referrals | Rehabilitation (Long-Term) | Rehabilitation Substance Abuse |
| | **P** | **A/D** | **RR** | **T** | **H** | **CC** | **MR** | **$R^{LT}$** | **$R^{SA}$** |
| Pediatrician / Family Practice / Health Providers | P | A/D | RR | T | | | MR | | |
| Community / Public Mental Health Providers | | | | | | | | | |
| - Child Guidance | P | A/D | RR | T | H | CC | MR | | |
| - Northwest Behavioral | | A/D | RR | T | H | CC | MR | | |
| - Mental Health Resources Center | | A/D | RR | T | H | CC | | | |
| Private Mental Health Providers | | | | | | | | | |
| - Shands | | A/D | | | H | | | | |
| - Nemours | | A/D | RR | T | H | | | | |
| - Hope Haven | | A/D | RR | T | H | | | | |
| - Private Practice | | A/D | RR | T | H | | MR | | $R^{SA}$ |
| - Psychologist | | A/D | RR | T | H | | MR | | |
| - Social Worker | | A/D | RR | | H | | MR | | |
| - EAP | | A/D | RR | T | | | MR | | |
| Angelwood (residential) | | | | T | | | | | |
| CARD | | | RR | T | H | CC | | | |
| Child Find | | | RR | | | | MR | | |
| Church / Clergy | P | | | | | | MR | | |
| Daniel (residential) | | | | T | H | CC | MR | $R^{LT}$ | |
| Developmental - Dr. Childers & Dr. Belsito | | A/D | | T | | | MR | | |
| Developmental Services | | | | T* | | CC | MR | | |
| Early Learning Centers / Preschools | | A/D | | | | | MR | | |
| Early Steps | | A/D | RR | T* | H | CC | MR | | |
| ER (Shands & Wolfson) | | | RR | | | | MR | | |

| Access Points | Service provided | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Prevention | Assessment/Dx | Reveive Referrals | Treatment | Habilitation | Care Coordination | Make Referrals | Rehabilitation (Long-Term) | Rehabilitation Substance Abuse |
| | **P** | **A/D** | **RR** | **T** | **H** | **CC** | **MR** | **$R^{LT}$** | **$R^{SA}$** |
| FDLRS | | A/D | | T | | | MR | | |
| Even Start | | A/D | | | | | | | |
| Family Counseling Services | | A/D | RR | | | | MR | | |
| Foster Care | | | | T | H | CC | MR | | |
| Full Service Schools | | | | T | H | CC | MR | | |
| Gateway | | | RR | | | CC | MR | | $R^{SA}$ |
| Healthy Families | | A/D | | | | | MR | | |
| Healthy Start | | A/D | | T | | | MR | | |
| Homeless Shelters | | A/D | | T | | CC | MR | | |
| Hubbard House | | A/D | | T | | CC | MR | | |
| Jail / Sherrif | | | | T* | | | | | |
| Jacksonville Children's Commission Programs | | A/D | | | | CC | | | |
| Jericho (residential) | | | | T | H | CC | | | |
| Jewish Family and Community Services | | A/D | RR | T | | | MR | | |
| Juvenile Dependency | | A/D | | T | | | | | |
| Juvenile Justice | | A/D | | T | | | MR | | |
| Law Enforcement | | | | | | | | | |
| Mental Health Association (MHA) | P | | | | | | | | |
| Mental Health Resource Center (in-patient) | | | | T | | | MR | | |
| National Alliance for the Mentally Ill (NAMI) | | | | | | | | | |
| Schools - ESE | | A/D | | | H | | | | |

| Access Points | Service provided | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Prevention | Assessment/Dx | Reveive Referrals | Treatment | Habilitation | Care Coordination | Make Referrals | Rehabilitation (Long-Term) | Rehabilitation Substance Abuse |
| | **P** | **A/D** | **RR** | **T** | **H** | **CC** | **MR** | **$R^{LT}$** | **$R^{SA}$** |
| SEDNET (Severely Emotionally Disturbed Network) | | | | | | | | | |
| Ten Broeck (in-patient & residential) | | | RR | T | | | MR | $R^{LT}$ | |
| The Bridge | | A/D | | T | | | MR | | |
| Therapeutic Foster Care (Boys' Home & Children's Home Society) | | | | | | | | $R^{LT}$ | |
| United Way | | | | | | | info | | |
| Wolfson (in-patient) | | | | T | | | MR | | |
| Youth Crisis Center | | A/D | RR | T | | | MR | | |

* Contracts for services