Center for Health Policy Research

College of Osteopathic Medicine
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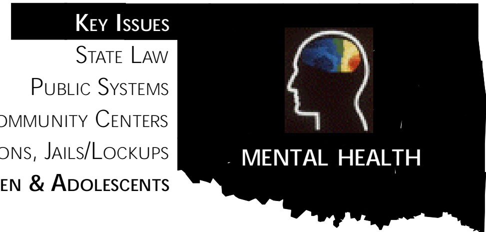
Health & Medicine Issue Paper ▲▲▲

● THE SIXTH IN A SERIES ●

Our Children and Adolescents



Title 43A §1-104. Public Policy

> **The Oklahoma Legislature hereby declares that the public policy of this state is to assure adequate treatment of persons alleged to be in need of mental health treatment ...**

We are witnessing the unintended consequences of 30 years of cultural and behavioral change. This change has been accelerated by the fragmentation of the family, legal actions, both illegal drug use and the abuse of legal drugs, and society's inability to rapidly create diagnosis and treatment models for the ever-evolving and mutating problems being displayed by some children and adolescents.

Childhood mental illnesses/disorders, and severe emotional disturbances, appear at odds with juvenile justice codes and traditional methods of discipline. They are a huge challenge to the mental health care and juvenile justice systems. The knowledge base of causes and treatments is expanding rapidly. However, the public resolve to pay for these remedies is not fully formed nor consistent. This is true in Oklahoma and many other states.

The necessary evaluations and treatments require a well trained cadre of mental health professionals working within public systems that are coherent, integrated, and remunerative. Too often these elements are missing. and the public enthusiasm to support these elements is minimal. It is in this environment that public policy makers must allocate finite resources.

Oklahoma's Children/Adolescents

There are an estimated 984,000 children and juveniles in Oklahoma. Between 45,000 - 50,000 children are born each year. The 1998 census estimates show the following age groupings:

Ages	Number
0-8	467,000
9-17	435,000
18-19	82,000

This Mental Health Series

This series of papers has concluded that public mental health services are apparently Oklahoma's lowest public priority; and children are clearly the lowest priority within the public mental health service systems. This is not necessary.

Fragmented and limited services are not necessary, even with funding limitations. Emerging systems of care models offer an effective and efficient approach. Significant public leadership will be required.

The first five issues of this series on mental health were primarily oriented toward the general public. Children and adolescents are very different; their mental health needs require a significantly different diagnostic and treatment process. Adult mental heath treatments are evolving toward the precise application of psychopharmacological treatments ... that is medications. Such a wholesale approach to children is likely both irresponsible and dangerous.

The Oklahoma record in providing mental health services is not very good. The record for children's services is abysmal. Our state struggles with this emerging health issue as do others. But we likely don't "struggle" nearly as much as others.

Michael Lapolla, Director

Prevalence data indicates that 9-13% of children between 9-17 will cope with mental/addictive disorders. The duration and severity will vary greatly. The prevalence factors in Tables 1-2 are reported by the MECA Study (Methodology for Epidemiology of Mental Disorders in Children and Adolescents) that is cited in the recently released Mental Health: A Report of the Surgeon General.

Table 1
Prevalence of Disorders in Children, by Type
Source: Mental Health: A Report of the Surgeon General

Disorder	Pct	Oklahoma
Anxiety disorders	13%	56,550
Disruptive disorders	10%	43,500
Mood disorders	6%	26,100
Substance abuse disorders	2%	8,700

Table 2
Prevalence of Disorders in Children by Severity of Impairment
Source: Mental Health: A Report of the Surgeon General

Disorder	Level	Pct	Oklahoma
Any disorder	Extreme	5%	22,000
Any disorder	Significant	11%	48,000
Any disorder	Minimum	21%	91,350

For practical purposes, this brief will presume 5-11% of Oklahoma's children (ages 9-17) may require significant services. This would equate to an estimated 22,000 - 48,000 kids requiring services atany given time. It is likely that fewer than 20% are receiving meaningful services and care.

Gradations of Disorders
Where does undisciplined bad behavior end ... and mental illness/disorders begin? It is very difficult to know without the involvement of well trained professionals.

The evaluation and assessment of children's mental health needs are subtly, yet significantly, different from adult needs. That is a major impediment to securing general public support for children's mental health needs.

It is becoming evident that much of severe mental illness is biologically based. Many disorders likely have molecular/genetic causes that are just beginning to be understood. Additionally, children's problems are often masked by parenting and the maturation process. Other contributing reasons include lasting trauma caused by abuse and neglect, and the shortage of trained professionals to properly recognize symptoms in a timely manner.

Public Funding
It is likely that the average person would presume that the Oklahoma Department of Mental Health would be the "lead" public agency in applying public dollars and policies. In fact ... this department is only one of six agencies dealing with children's mental health issues. It only accounts for 6% of expenditures ... and 2/3 of that money is allocated to either the Oklahoma Youth Center or substance abuse treatment. In addition, the Department has only placed nominal efforts solely targeting children. Until very recently the Department only employed a single individual to focus upon children.

The Oklahoma Health Care Authority (Medicaid) accounts for half (49%) of expenditures. The Departments of Human Services and Education account for another 38% of expenditures. These three agencies account for 87% of all children's mental health outlays. Funds flow between agencies as services are rendered by each for each. But, in reality, there is little program and services coordination between the agencies past coordination of finances.

Clearly the Oklahoma Health Care Authority is the primary source of public funds. Last year the state budget process led to the Authority significantly reducing, then partially restoring funds for children's mental health services. Measures such as these add to the instability of services

The state of Oklahoma is experiencing the consequences of constitutional caps on state tax revenues. As the state provides funds for more well supported functions (education, corrections, transportation) there is a dwindling amount being directed toward mental health services. Given this reality, Oklahoma cannot misdirect a single dollar on care models that are not efficient and effective.

Mental Health Care Models

Institutions
The historical response to all mental health service needs has been to create institutions to house the patients. The reasons were sound and simple. Very little effective treatment was possible. Public and patient safety could be best preserved, and limited services best rendered, by housing all patients in a centralized setting. Control was easy to exert. Staff was easy to centralize.

The most well-intentioned institutions generally devolve into places where the patient needs eventually fall subservient to that of the institution. And, over time, institutions likely will deviate from the original intention and create dissatisfaction. Mental health treatment protocols have become more sophisticated and effective. As that happened, the role of the

Table 3
State of Oklahoma FY 2000
Estimated Expenditures: Children's Behavioral Health
Source: State Representative Joe Eddins, Chairman
Mental Health Committee, Oklahoma House of Representatives

Agency	Millions	Pct
OK Health Care Authority	$92	49%
Department of Human Services	$45	24%
Department of Education	$27	14%
Department of Mental Health	$10	5%
Department of Health	$9	5%
Office of Juvenile Affairs *	$5	3%
Statewide Totals	$189	100%

* does not include expenditures by youth services agencies for outpatient behavioral health services.

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institution conflicted with the more flexible and possible environments. Patients would receive a few hours of service and then spend many hours in a restrictive non-productive environment. Eventually, contemporary mental health policy emphasized community based services as opposed to institutionalization. In Oklahoma, class action lawsuits accelerated the change.

Community Services

The provision of community-based mental health services was an idealistic policy that was poorly executed. They initially required an appropriate funding level that was never forthcoming. They required all patients to navigate a bewildering array of services ... or pseudo-services. They also required an individual patient discipline that was unreasonable for patients to exhibit. The result was non-compliance rates that proved both detrimental and embarrassing, and an overcomplication of integrated services.

In these services, patients would receive a few hours of service and then spend many hours in unstructured environments. Adaptation was difficult and uneven. This model is evolving into a "systems of care" approach to delivering services within a community.

Systems of Care (Severe Problems)

An emerging "systems of care" model combines the advantages of institutionalization (critical mass of expertise) and community services (decentralized, customized, and flexible). It emphasizes teams of coordinated professionals operating in a specific community while focusing upon children's needs in the home and school.

The teams deliver the necessary mix, volume, and intensity of services within a community/family environment. The model is a product of both innovative and comprehensive federal grant initiatives ... and the frustration of systems that produce marginal results. This model is especially effective for children with severe mental health problems.

Environments play an important role in creating behavioral problems ... and in potentially solving them.

Conceptually, this approach delivers concentrated services to children and adolescents needing care within community, school, and family environments. Parents and other family members have been traditionally excluded from problem-solving and empowering the child. In the "system of care" model, family members are key players on the care team.

The services are tailored to meet the individual needs of each child, and the philosophy is that this team will "do whatever it takes" to support and encourage the child and to assure the child's success in reaching the highest level of developmentally appropriate functioning possible in family, school, and community settings.

Additionally, the care team may involve others significant in the child's life, including teachers, pastors, leaders in youth programs, and other supportive adults. With information and support from family members and others, treatment providers are better able to evaluate and diagnose the child because they observe and work within the very environments in which the child's difficulties in functioning are most evident. Thus, the child and family are better served because care is tailored to individual needs, rather than seeking to fit the child into an existing program. (See Table 4, above)

Table 4

System of Care Principles vs. Care Models

Principles	Public Institutions	Community Based	Systems of Care
Family Focused	No	No	Yes
Culturally Competent	Maybe	Maybe	Yes
Interagency	No	No	Yes
Community Based	No	Yes	Yes
Accessible	No	Yes	Yes
Coordinated	No	Maybe	Yes
Individualized	Maybe	Maybe	Yes
Least restrictive	No	Maybe	Yes

The eight (8) system of care principles have been published by the evaluation team of the CMHS National Evaluation. The presence of these principles in the three care models is the assessment of the OSU Center for Health Policy Research and data provided by the CMHS evaulation team.

There is an important caveat. Does Oklahoma have a sufficient cadre of properly trained and credentialed professionals to execute contemporary care systems statewide? It is more than likely we do not. This lack of professional infrastructure is beyond the scope of this paper and should be the subject of a separate study.

Systems of Care (Significant Problems)

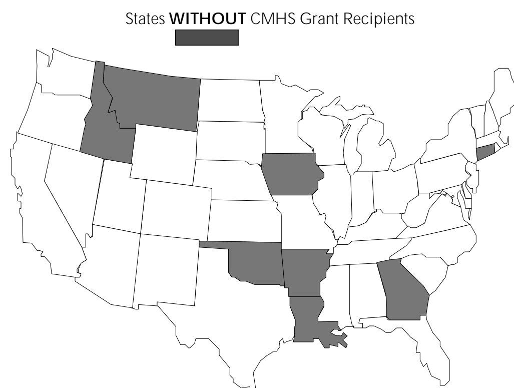
The above model focuses upon children with severe problems. Other approaches are better suited for less acute needs. An example of a well-researched and effective model, is based at the Search Institute in Minneapolis (www.search-institute.org). The Institute conducts research and evaluation, develops publications and practical tools, and provides training and technical assistance. The Institute collaborates with others to promote long-term organizational and cultural change that supports the healthy development of all children and adolescents. Oklahoma should listen.

Figure 1

CMHS Grantee States/Communities

Comprehensive Community Mental Health Services for Children & Their Families Program

States **WITHOUT** CMHS Grant Recipients



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A Federal Initiative

Many states and localities have participated in the comprehensive federal grant program exploring Systems of Care: Promising Practices in Children's Mental Health. Oklahoma has not. "This multi-million dollar grant program is demonstrating effective approaches to serving the needs of many of the 3.5 to 4 million children with serious emotional disturbance living in this country." (see "http://www.air-dc.org/cecp/promisingpractices" for entire report).

This program has been operating annually since 1993. There have been 65 grants awarded to communities in 42 states . Of the eight states not participating (see Figure 1, below), only Georgia and Louisiana are larger than Oklahoma. This is a loose measure of the low public priority for children's mental health in Oklahoma. The quotes below are from the evaluation document of the program:

> *"We now look to parents as a source of the solution, not the cause of the problem." Agency Administrator*
>
> *"So much of what we have accomplished is based upon relationships and not on the slow process of changing policies." Agency Staff*

An Oklahoma Initiative

The Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS) has crafted a pilot program similar to the federal demonstration projects ... but without the federal money and program support.

The five key state agencies funding children's mental health services in Oklahoma have agreed to fund a pilot program in Kay County. The program will operate for three years. The agencies and annual commitments are below:

Kay County Pilot Project

State Agency	Annual
OK Commission on Children and Youth	$100,000
Department of Mental Health	$ 67,000
Department of Human Services	$61,000
Office of Juvenile Affairs	$61,000
OK Health Care Authority	$ 30,000
Annual Commitment	**$319,000**

The program will become operational in July 2000. This program will cost an estimated $319,000 ... and provide services for 45 severely disturbed children. This is an estimated $7,000 per child per year.

The total sounds large until one realizes that Oklahoma is expending about the same amount for 30,000 kids statewide today (see table 3). And most agree the efforts are significantly under-funded. However, most statewide efforts are neither local nor highly coordinated. Almost no significant evaluation and/or treatment is in the home or with significant family participation. The initial purpose of the demonstration project is to expend the same dollars more efficiently and effectively with better outcomes.

Some Recommendations

It is glib and tempting to say that our pubic mental health systems require a complete overhaul and integration. That may be said about many things ... both public and private. In reality we have what we have ... and it is from there that improvements must begin.

It would seem that, by definition, the Oklahoma Department of Mental Health and Substance Abuse Services must be the lead agency in developing a coherent public policy and public response to children's mental health issues. That agency is without executive leadership.

One would trust that the responsibility for policy development would remain with that Department. And it is suggested that government not rashly transfer this function to another agency for purposes of short-term convenience.

Some specific recommendations follow. They are not meant to be all-inclusive. But they are a place to start.

- The Department of Mental Health and Substance Abuse Services must provide public services, with limited dollars, for a population most difficult to treat. They offer treatments and cures that even loving families cannot provide for family members. It is suggested that the very first and most important action it can take is to establish formal standards for children's care. Such standards must not be punitive criteria for reimbursement ... but rather significant a timeline, goals, and protocols to help parents and providers measure their progress with children in need.

- If the interim progress of the Kay County project looks promising, the Legislature, and appropriate state agencies, should consider providing encouragement/support for at least six additional pilot programs. At least one should be in Tulsa or Oklahoma county. Another should be in a "regional" county such as Garfield, Comanche or Pittsburg. The other four should be in smaller counties in each state quadrant.

- The Legislature should consider adding an additional forensic evaluation and treatment capability to the Oklahoma Youth Center. Such a unit will be for a small number of juveniles not served by existing services.

- A public agency "Summit" should be convened by the Secretary of Health & Human Services. The Summit should examine how existing funds may be applied differently and collaboratively to achieve maximum efficiency and effectiveness. Internal block funding, blended funding and other techniques may help streamline both financing and program administration in the interests of better services.

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Table 5

State of Oklahoma FY 2000

Sources of Estimated Children's Behavioral Health Budgeted Expenditures

Source: Representative Joe Eddins, Chairman, Mental Health Committee, Oklahoma House of Representatives

	Federal	State	Local	Total
Oklahoma Health Care Authority				
Outpatient Services (Ages 0-17)	40,265,188	17,256,509		57,521,697
Inpatient Services (Ages 0-18)	24,386,321	10,451,281		34,837,602
Sub-Totals	**64,651,509**	**27,707,790**		**92,359,299**
Department of Human Services				
Therapeutic Foster Care	20,050,957	8,593,268		28,644,225
Group Homes	3,547,440	4,702,420		8,249,860
Home-Based Services		6,963,121		6,963,121
Outpatient Services		922,122		922,122
Inpatient Services		499,713		499,713
Sub-Totals	**23,598,397**	**21,680,644**		**45,279,041**
Department of Education				
Medical Services	16,207,798	10,805,199		27,012,997
Sub-Totals	**16,207,798**	**10,805,199**		**27,012,997**
Department of Mental Health				
Oklahoma Youth Center		3,798,272		3,798,272
Contract Sub Abuse Treatment	1,356,505	1,356,505		2,713,010
Contracted CMHC	615,000	1,937,095		2,552,095
State CMHC		1,452,483		1,452,483
Sub-Totals	**1,971,505**	**8,544,355**		**10,515,860**
Department of Health				
Child Guidance Centers		6,616,753	1,248,213	7,864,966
Intervention		919,606	229,900	1,149,506
Sub-Totals		**7,536,359**	**1,478,113**	**9,014,472**
Office of Juvenile Affairs				
Residential Eval/Counseling	997,308	2,346,538		3,343,846
Non-Residential Eval/Counseling		967,329		967,329
Diagnostic/Evaluation Testing	164,718	70,593		235,311
Sub-Totals	**1,162,026**	**3,384,460**		**4,546,486**
TOTALS	**107,591,235**	**79,658,807**	**1,478,113**	**188,728,155**

* does not include expenditures by youth services agencies for outpatient behavioral health services.

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With Mental Health Services Responsibility

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Bill Crowell, M.D.,	Chickasha
Beverly Eubanks	Oklahoma City
Paul Heath, Ed.D.	Oklahoma City
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John C. Hugon	Duncan
Mary Nichols	Tulsa
Ron Shamblin	Enid

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Mr. Wayne Hoffman	Poteau
Mr. Jerry Humble	Claremore
Mr. Charles Ed McFall	Frederick
Mr. George Miller	Bethany
Mr. Lyle Roggow	Enid

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