The Mental Health System for Low-Income Children:

The Philadelphia Story

Philadelphia Citizens for Children and Youth
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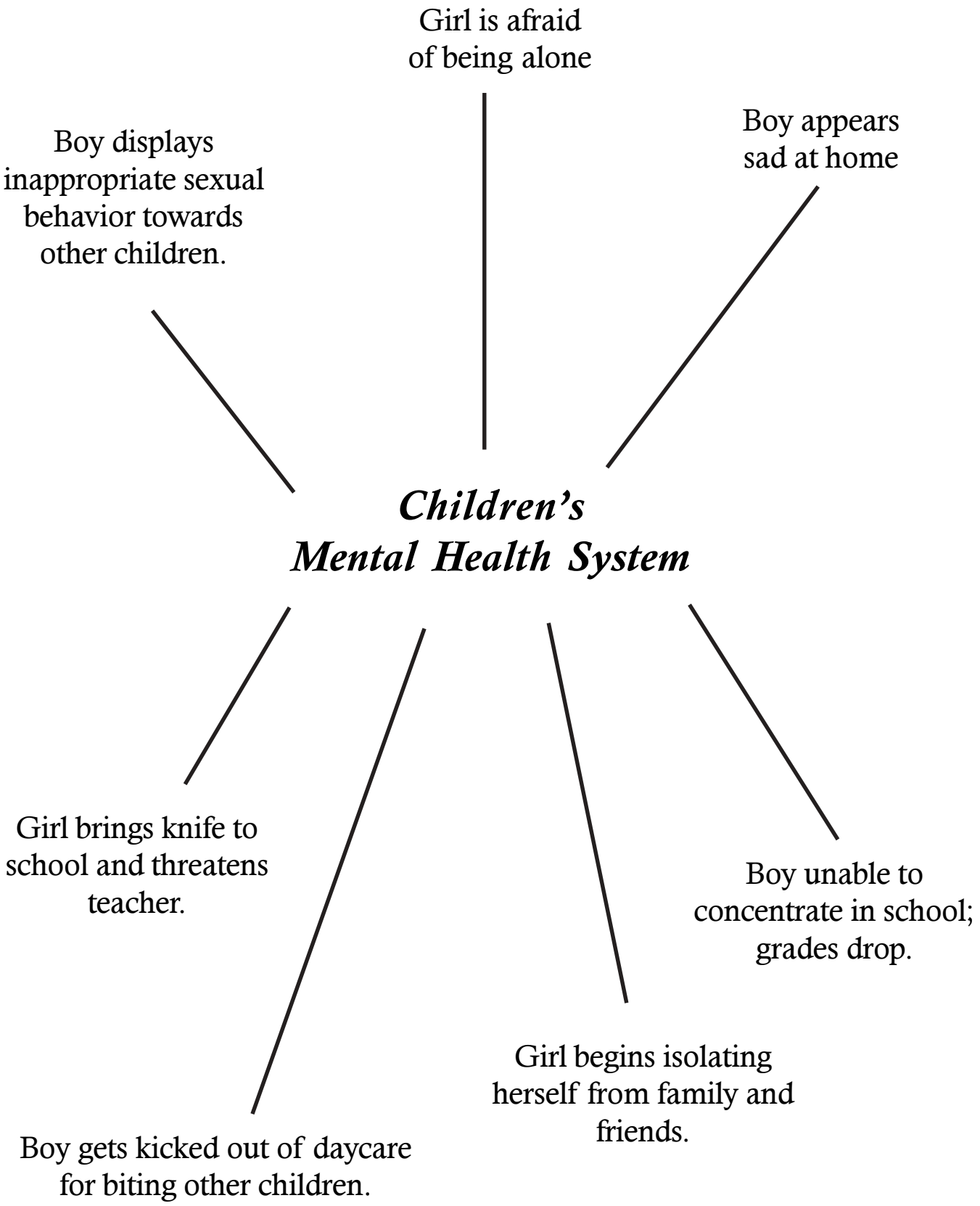
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Executive Summary

The Mental Health System for Low-Income Children

Executive Summary

Each year, approximately 42,000 children and adolescents in Philadelphia experience mental health problems. The majority of these youngsters come from families whose incomes are low and whose health insurance is provided through Medical Assistance. Some of these children are treated in their homes, some in their communities, and some in residential placements or hospitals. Some children are not treated at all.

In the last several years, our schools and our communities have become more conscious of the mental health needs of children. In our neighborhoods, child care settings, schools and homes, children and families struggle to better understand and respond to these needs. In the last year, Philadelphia Citizens for Children and Youth explored the mental health system for children and adolescents covered by Medical Assistance in the City. We found both major advances and major gaps in the system. Our findings include:

- Philadelphia's Behavioral Health System (BHS), the public insurer for all children and adults in Philadelphia on Medial Assistance, generally approves requests for needed services and rarely denies services.

- The different systems that serve children (juvenile justice, child welfare, schools, and mental health) are disconnected and thus service delivery is often fragmented.

- Mental health services and each level of care (outpatient, inpatient, residential) are often isolated from each other.

- The publicly-funded behavioral health emergency room for children is often overloaded and inconvenient for many of the City's families.

- The outpatient system, which provides critical linkage and services, including individual and group therapy, as well as case management in the community, is unable to meet demand. This lack of capacity often results in long waiting periods for children who need care quickly.

- The capacity and range of residential care programs in the region appears inadequate to serve the universe of need, but lack of system capacity information makes this assessment difficult.

- The major children's hospitals in the City do not have contracts with the behavioral health system which further fragments care.

- The shortage of mental health professionals serving the Medicaid population makes expansion of services difficult. Low reimbursement rates for outpatient services are frequently cited as exacerbating this problem.

- Mental health services are unevenly distributed in the schools.

- In recent years, the use of Therapeutic Staff Support (T.S.S.) service has grown exponentially. BHS is now cutting back and/or reshaping this service. The consequences of this reshaping are not yet known.

This paper outlines some goals and strategies to improve the delivery of mental health services to children and adolescents on Medical Assistance. Our hope is that the City and State will continue to take a leading role in investing in the emotional health of Philadelphia's children - their, and our, futures rely on it.

Vision for the Children's Mental Health System

The Mental Health System for Low-Income Children

Vision for the Children's Mental Health System

Taking Care of Children with Mental Health Care Needs

Children live in families and in communities. Services that respond to children's needs should be embedded in and enriched by service systems that are linked with families and communities. Many children in Philadelphia need mental health services, but often treatment for their behavioral health problem is only one of their many needs - many of these children, like all children, need child care, physical health care, education and services from the child welfare system and the juvenile justice system. The mental health system cannot stand alone but rather must be integrated with the family, community and institutions that help support our City's children. We thus must move away from thinking about individual children's services as existing in silos - and instead envision a system of connectors that creates one coherent system to improve the lives of children. Within this system, large institutions such as the School District, the Department of Human Services and the Behavioral Health System must break down the barriers around language, job definition, services and practice that keep them separate and distinct.

Key Components of a System of Mental Health Care for Children, Adolescents and Their Families

All systems of care for children need to have similar attributes; they must start and end with the family. They must identify problems as early as possible, respond to crises, provide short and long range treatment and involve parents, families and children as much as possible. In the mental health system, the components look like this:

- ***Prevention and early intervention*** - Provides children and families supports critical to child development. These services and practices are critical to child and family development; they are essential to a well-functioning system that responds to children and family needs.

- ***Early Identification*** - Make sure that early signs are noted and responded to in schools and in other community setting, children who withdraw, have difficulty interacting, seem troubled or preoccupied, or experience behavior change are identified early and provided treatment before their mental health problems worsen (see pages 15 and 18).

- ***Assessment/Evaluation/Diagnosis*** - Determines an appropriate plan for treatment and supports to treat children and adolescents. Assessment, evaluation and diagnosis occur primarily in the outpatient setting (see pages 15 and 18).

- ***Crisis/Emergency Services with Safety Plans*** - Works with children and adolescents in crisis to stabilize them and ensure appropriate aftercare. The emergency room is the most common site for crisis treatment and plans (see page 22).

- ***Clinical Treatment*** - Provides a wide range of treatment options and supports for children and adolescents and their families to address behavioral health needs. Treatment usually takes place in outpatient (see page 15), schools (see page 18), inpatient (see page 25), residential (see page 28) and day program (see page 30) settings.

- ***Care Coordination/Case Management*** - Develops a process to ensure children and adolescents receive all needed care and supports in a timely manner.

- ***Family Support*** - Providing concrete supports for families such as assistance with transportation, family support groups and respite care. These should occur throughout the system at every level of care.

Recommendations

The Mental Health System for Low-Income Children

Recommendations

Coordinate, Collaborate, Connect and Increase Capacity

The system as a whole must be more connected

- Coordination and communication between each part of the mental health system and between the mental health system and other child-serving systems must be improved.

- Collaboration should be incentivized so that providers are reimbursed for assuring that children are connected to all levels of care.

- A pilot program to encourage networks of providers to work together to strengthen the communication and connectedness of the system should be developed.

- Data should be collected to more accurately measure system capacity and document problems experienced by children and families.

- Children should not be discharged from residential or inpatient treatment without next steps in place.

- A forum should meet regularly to bring together BHS providers, consumers and stakeholders to regularly assess progress, review data and ensure that children throughout the city have access to mental health services.

- Concrete supports for families of children with mental health problems should be provided.

Individual parts of the mental health system must be able to perform their missions

Most of the different parts of the system need to work together with the support of the State, the City and the community. We must make some changes to improve the system and the chances for our children.

<u>The Outpatient system</u>

The outpatient system is a critical link between levels of care services and a care provider. When the outpatient system is unable to see a child who has left the emergency room, or residential care, or the family who is concerned about the child's school or home behavior, the whole system and children and families suffer.

- We must expand capacity to meet demand. Where necessary that may mean increasing hours and days for service as well as increasing reimbursement rates or creating a differential rate schedule that pays providers based on their qualifications.

<u>Hospitals</u>

- We must assure that our children can get the outpatient & inpatient care they need. Therefore Philadelphia's children's hospitals must apply for the necessary licenses and contract with BHS to assure that low income children are provided appropriate care.

Schools

- We must develop an interagency collaborative structure to oversee mental health services in schools, improve relationships and communications between schools and the mental health system, and ensure adequate mental health supports in all City schools.
- We should simplify the licensing process to increase the number of licensed mental health programs able to conduct school-based assessment and therapy.

Emergency Room

- Establish a second mental health emergency room for children.
- We must connect all children from the emergency room to the next arm of the system, whether it is inpatient hospitalization or outpatient therapy. This connection requires direct contact within 24 hours.

Inpatient

- We should assure that all children are discharged from inpatient facilities with detailed individual plans for treatment and support, that they are connected to the next level of care and that all appropriate parties (e.g. schools and pediatricians) are informed.

Day Treatment Programs

- We should develop more day treatment programs for children of different ages.

Residential

- Provide adequate and appropriate residential treatment facilities for children of all ages.
- We must emphasize the importance of discharge planning to ensure children have adequate supports in place before returning to the community.

Introduction

The Mental Health System for Low-Income Children

"The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country. Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them."

- David Satcher, M.D., Ph.D.
Assistant Secretary for Health and Surgeon General

Introduction

The Surgeon General estimates that approximately 11% of children and adolescents nationally suffer significant impairment from an emotional or behavioral problem. Philadelphia is home to nearly 390,000 youth under 20 years of age; we therefore estimate that about 42,000 youth experience significant mental health problems in the City.

While mental health problems are found in rich and poor communities, cutting across socioeconomic and cultural lines, the incidence is estimated to be higher in low-income families. More than half of the children who live in Philadelphia are enrolled in Medical Assistance, the Commonwealth's Medicaid program. That is good and bad news. The good news is that these children have health insurance coverage and can benefit from a system designed to be comprehensive and to provide services as needed without consideration of payment. The bad news is that the system has been overwhelmed by the need to provide services to so many children.

It has taken a long time to recognize mental illness as a childhood problem; it has taken even longer to develop system capacity to treat these children. The City has developed a system that is committed to serving all children and to providing an array of services in settings that are responsive to the needs of children and families. But the system struggles with capacity and funding problems, resource and staffing difficulties and with the distance between its vision and the reality for many children.

- There are nearly 390,000 children in Philadelphia
- 210,000 of these children receive health insurance through Medicaid

Of those children who receive health insurace through Medical Assistance:

- Nearly 20,000 children received outpatient mental health treatment in 2001
- 3,000 children were seen at the children's mental health emergency room
- More than 2,100 children received inpatient treatment
- Nearly 1,500 children were in residential treatment for a mental health problem
- Over 2,500 children were in a partial or day treatment program
- More than 1,700 children received case management services

Last year 215,000 children attended Philadelphia public or charter schools. About 79% of these children are from families whose income is low. Most of these children are enrolled in publicly supported health insurance programs. Some of these children benefited from the 79 Consultation and Education Specialists (C & E's) in schools who helped identify problems and link kids to services. Other children were assisted by the hundreds of Therapeutic Staff Support (T.S.S.'s) personnel in schools throughout the City, and about 800 other children were served through the Student Assistance Programs (SAP) in 75 schools, while about 300 students received help through school-based mental health clinics.

But still the system has gaps and voids.

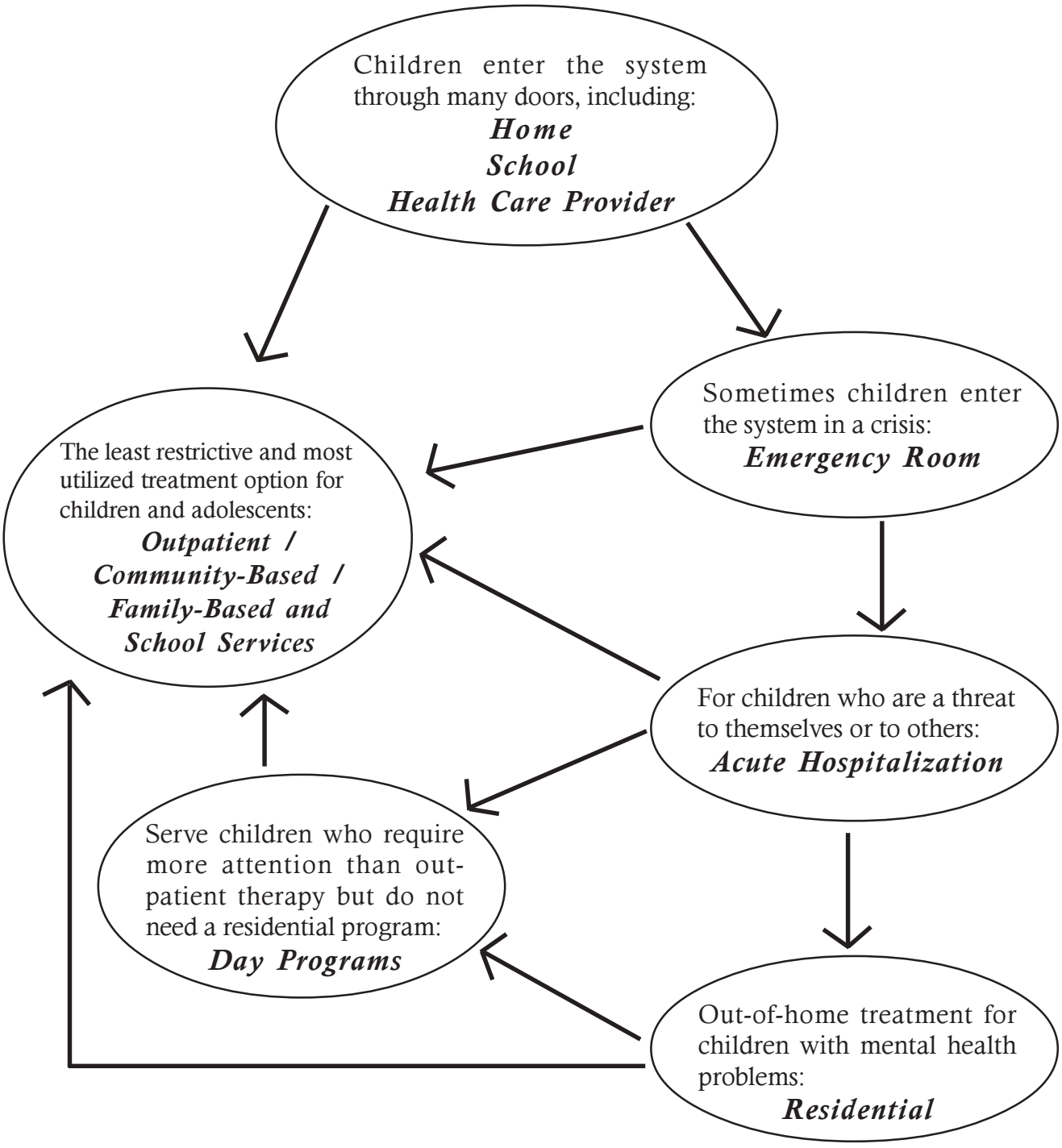
It is not easy to provide an integrated, comprehensive mental health service program to children in a large city. The entryways have to be many; the services have to be easy to access yet efficient and economical; the paths should be direct yet provide for the complexities of individual needs. There are not whole models that can be adopted. Despite the difficulty, major steps have been taken - our children have health insurance and are enrolled in a system whose purpose is to serve them.

Some of the next critical steps are: securing and retaining enough qualified mental health professionals willing to work in the public sector; providing quality, timely services that are easily accessible in community settings; breaking down the regulatory, practice and language barriers that prevent collaboration among child-serving systems; securing the funding necessary to do it all. Adequate funding is necessary and influences all the other factors, but funding alone is not sufficient for the system to live up to its vision.

Like threads in a tapestry, the whole is dependent on its individual parts; when one thread is weak or missing, the design is threatened. When children and youth with emotional disturbances do not get the timely, appropriate care and supports they need, they can often be found in other systems such as child welfare or juvenile justice. Whether these children could have avoided landing in these systems for help, we can't know. We do know that some children are not even identified as needing mental health treatment until they are in the child welfare or juvenile justice systems. We also know that rates of emotional disturbance among youth in the juvenile justice system are significantly higher than in the general population. Most experts believe that untreated mental health problems grow worse as children grow older. Some estimate that at least three-quarters of adults with a mental health problem had recognizable difficulties during childhood and adolescence. Thus there is consensus in support of early treatment and support for children and families experiencing mental health problems. The City of Philadelphia is working to act on that consensus.

While we spoke with many people who work inside the system, many who are in positions of leadership, PCCY presents this report as an outsider's efforts to understand the children's mental health system, its strengths and weaknesses, as reflected through readings, observations and interviews with providers, administrators, advocates, health care practitioners, parents and children to work to improve its future.

Chart #1 - Pathways Through the Mental Health System



After being identified or receiving care by the outpatient system, a school or the emergency system, a child can be referred to the other arms of the system which include partial, residential and inpatient care. Because of the nature of the mental health system, children recycle back to the outpatient system after being treated in most other parts of the system.

Philadelphia's Medicaid Behavioral Health System

The Mental Health System for Low-Income Children

Philadelphia's Medicaid Behavioral Health System

""We are seeing more and more kids in trouble, more kids who need help . . . We are hurting our City's children because as their numbers and needs have increased, our system has become overwhelmed and unable to really help the thousands of kids who need us."

- A Provider

Vision and Reality

Philadelphia's Behavioral Health System has received national recognition for its vision and commitment to providing mental health services to people with low incomes. The uncommon achievement is that there is a system of care for children on Medical Assistance that is considered superior to what is available to privately insured children.

***Vision* - to create a children's mental health system that provides a wide range of effective treatment options available to all kids in need of care without concern about the family's ability to pay.**

***Reality* - we found that the system does provide a broad range of treatment options and rarely refuses requests for treatment. The other reality is that the system does not have the capacity to respond to demand.**

Overview

With the support of the Commonwealth, Philadelphia created a public authority to oversee its Medicaid system for behavioral health. The Community Behavioral Health system (CBH) was designed to provide a comprehensive system of behavioral health care to low income residents of the City. The creation of a non-profit managed care system to be managed in the public interest was widely acclaimed as a giant step forward. CBH combines with several other agencies including the Coordinating Office for Drug and Alcohol Programs (CODAAP) and the Office of Mental Health and Mental Retardation (OMH/MR) to support a broad range of services funded by different agencies whose collective goal is to provide mental health and drug and alcohol programs and services to low income individuals in the city. The combined entity is called the Behavioral Health System (BHS).

BHS plans, coordinates and supports the delivery of mental health services to adults and children who are either uninsured or receive Medical Assistance. The services are provided through contracts with more than 300 providers who offer a wide array of services to about 75,000 children and adults annually. These services include outpatient treatment, inpatient and partial hospitalization and residential and emergency services. Services are delivered in homes, in the community-base mental health clinics or outpatient treatment centers, in schools, in hospitals and in residential treatment facilities.

Despite the significant investment and improvements the City and State have made in the children's mental health system in the last decade, children still have difficulty accessing services in a timely fashion. In general, the needed programs are in place, but there are not enough services available and not enough staff to treat children. Many of the other child-serving systems are overloaded and under-resourced and place increasing demands on the mental health system.

Only one mental health emergency room for children enrolled in medical assistance exists in the City, and it is often overcrowded and unable to see children in a timely manner. The outpatient system is unable to meet the needs of new patients or those leaving residential care or the emergency room. Insufficient and stagnant reimbursement rates discourage treatment providers and staff, leaving children waiting weeks or months to secure therapy. The scarcity of child psychiatrists results in children experiencing long waiting times for evaluations, while long-standing practices and confidentiality issues are cited as hindering information sharing and collaboration among other systems.

Nevertheless, we believe the elements are in place to move the system's reality closer to its vision.

Philadelphia's Medicaid Behavioral Health System

The Mental Health System for Low-Income Children

- ***Outpatient and Community-Based System***
- ***Schools***
- ***Emergency System***
- ***Inpatient Hospitalization***
- ***Residential Treatment Facilities***
- ***Day Treatment/Partial Programs***

Outpatient System

Provides Early Identification, Assessment/Evaluation/Diagnosis, Clinical Treatment, Care Coordination/Case Management, and Family Support

***Vision* - Most children who require care should be able to have that provided in an outpatient setting in their community. The outpatient system should be able to provide services without undue waiting time for appointments and should be able to accept referrals from schools, homes, pediatricians, emergency rooms, and hospitals. The outpatient system should link children to other appropriate care.**

***Reality* - We found the outpatient system unable to respond to the demands placed on it, triggering waiting lists for evaluations and services for new patients, and long waiting times for appointments for those discharged from hospitals or emergency rooms.**

Outpatient therapy is the least restrictive, most utilized and least expensive treatment option for children and adolescents. Services can occur at a mental health provider's office or at a child's home or school. The outpatient system offers a wide range of clinical services including, individual, group and family therapy, psychiatric evaluations, case management, crisis specialists, mentoring programs, mobile therapy, therapeutic staff support, therapeutic classrooms and medication management. Almost 20,000 children and adolescents received outpatient therapy in 2001.

The outpatient system is meant to provide readily accessible services to people in their communities. Treatment may range from several weeks to many years of therapy. The majority of outpatient treatment for children occurs at one of Philadelphia's 11 community mental health centers or at over 35 specialized mental health agencies. Most people we interviewed agreed that the range and quality of outpatient care varies widely.

The outpatient system acts as both an end in itself and a transitional treatment modality. Thus, when children are discharged from inpatient or crisis services, they are transitioned to outpatient services. This shortage of outpatient services in turn can place demand on other systems or other parts of the system. Families and school personnel may turn to emergency rooms because of the difficulty of securing timely treatment for an urgent although not emergency situation; pediatricians may receive requests for medications when they have not been part of the treatment team, inpatient facilities may keep children longer than necessary, or needs may be ignored when outpatient care is not available. During this delay a child's condition may worsen, sometimes escalating to an emergency situation.

Waiting Times for an Appointment

> *"I often send students to get mental health treatment because it is obvious to me that they need help only to find them put on a waiting list for out-patient treatment."*
>
> *- A School Nurse*

Waiting times to access outpatient services is a serious issue for children with mental health concerns. Long delays in getting appointments were reported by providers throughout the mental health system. In an informal point-of-time survey conducted by PCCY in September 2002, waiting times at the largest outpatient providers were found to range from one week to three months with an average of twenty-one days for an appointment with a therapist. When children have been referred for mental health treatment, they often need immediate help - three weeks is too long to wait.

Two outpatient providers with whom we spoke reported no longer accepting new patients because of long waiting lists and inadequate numbers of staff. Families reported a lack of enough evening or weekend hours and the difficulty of securing an appointment for a child who seemed to need immediate attention.

Waiting Times for Medication

Pediatricians with whom we spoke identified a frequent problem of children and adolescents being discharged from a hospital following a psychiatric crisis with only a few days worth of psychotropic medication. Once back in the community, children are often unable to obtain an appointment for medication before the medication they obtained from the hospital runs out. Abruptly being cut off medication with no medical supervision can leave children in difficult and dangerous situations. Often, parents of these children turn to their pediatrician who has sometimes not been included or informed of the of children's mental health history, including their medication history. One provider said, "Patients call following their hospitalization requesting medication that I didn't even know they were on. I don't know what the plan is, why they are on that medication or what the dose is, and I cannot get in touch with the psychiatrist. But the patients are saying 'We need it now or there is going to be a crisis, so I fill it for them." The need for better linkage between one service and another is evident. How we work together to create the necessary linkage is a challenge before us.

Waiting times for a Therapist

One reason for the long waiting times experienced by children and adolescents needing outpatient care is the lack of therapists and psychiatrists. Staff turnover at mental health centers is another problem which translates into more waiting for care for kids and families. The difficulty of securing and keeping skilled mental health practitioners is commonly recognized as a critical problem in all mental health systems, but particularly among those that treat low-income children. As one provider said, "People are working so hard to help the most vulnerable kids in our City and yet they are not paid enough, so they move onto other jobs."

Low reimbursement rates for outpatient therapy, particularly individual and group therapy, is often cited as the reason for the inadequate numbers of therapists providing these treatments.

The lack of enough providers willing to practice in the publicly-funded system plays out in different ways affecting treatment choice, as well as time. Two examples are group work and psychiatric evaluations. Group work is recognized by many as desirable for adolescents, but the difficulty of providing such therapy within the current reimbursement rate discourages its utilization. While the difficulties experienced in providing quality individual and group therapy sessions is recognized as a multi-faceted problem, including extensive paperwork and problems in patients complying with appointments, the lack of a competitive fee structure is significant. And the lack of child psychiatrists working in the Medicaid system makes it more difficult to provide assessments and evaluations. The inadequacy of the evaluation rate was frequently cited to us as resulting in children often not receive psychiatric evaluations - even though a good evaluation is essential to receiving appropriate treatment. BHS is trying to ameliorate this problem by allowing other providers, psychologists and therapists, to assist with evaluations. Concern that treatment plans are based on what services are available instead of what a child needs has led some advocates to stress the need for independent evaluation centers to determine what children need instead of what is available.

Philadelphia's Children's Hospitals don't provide outpatient mental health services to children on Medical Assistance

None of the City's three children's hospitals, the Children's Hospital of Philadelphia (CHOP), Temple University Children's Medical Center or St. Christopher's Hospital for Children have contracts with BHS to serve children on Medical Assistance. Although children with Medical Assistance can and do see providers at each hospital for their physical health needs, they must be referred out of the hospitals for outpatient mental health treatment. Because there is no contract or relationship with BHS, a child's physical health provider is often disconnected from his/her mental health provider. Ironically, there are many mental health specialists at these hospitals, some of whom are considered leaders in their field. But they are only able to treat privately insured children, even though they recognize the tremendous need for services among children on Medical Assistance.

The City/BHS should:

- **Build the capacity of the outpatient system to respond to current and anticipated demand.**
- **Contract with the local children's hospitals to provide outpatient care.**
- **Create protocols to link outpatient providers with schools and pediatricians to ensure continuity of care.**
- **Partner with the provider community and parents and children advocate for increasing the capacity of the outpatient system.**
- **Increase outpatient reimbursement rates to ensure quality outcomes.**

The City/BHS and State should:

- **Create incentives for therapy modalities and programs, like group therapy, that are recommended for children and adolescents.**
- **Incentivize communication and coordination between all parts of the mental health system.**
- **Increase reimbursement rates to attract and keep mental health professionals providing quality care in the outpatient system.**

Providers should:

- **Add additional hours and weekend times for appointments.**
- **Ensure walk-in capacity for children in need of urgent care.**

Children's Hospitals should:

- **Provide behavioral health services to low income children in the community.**

Schools

Provide Early Identification, Assessment/Evaluation/Diagnosis, Clinical Treatment, Care Coordination/Case Management, and Family Support

Vision **- Children belong in their schools and in their communities. The mental health system should collaborate with schools to jointly develop special processes and programs, assure the availability of crisis services and wraparound services to create a more accessible system and take the pressure off of other parts of the system.**

Reality **- The range of services available to children with mental health problems in the schools ranges from few to many; there are some schools with multiple services available for children and adolescents and some schools with almost no services. This erratic patchwork of services exists within a context of increasing child need and decreasing numbers of school personnel. This situation has contributed to unexpectedly high use of the emergency and crisis services by schools, the creation of some in-school programs and a broad use of therapeutic staff support (TSS - wraparound). Services are often uncoordinated where they do exist, or not known or accessible in schools where needed.**

While the community outpatient setting is generally the linchpin for mental health services, other settings provide some of these services as well. Because schools are where children are, they are increasingly recognized as sites for accessing the health care system. After the family, schools have perhaps the greatest influence on the development of children and are, therefore, necessary players in promoting mental health and providing mental health services. There is a growing recognition among educators, advocates, parents and communities that schools must tend to children's social and emotional health. The mental health of children is essential to school functioning and does not represent an agenda separate from a school's instructional mission.

Nearly 50% of kindergarten students identified with a behavioral problem are expected to receive special education services by fourth grade. Philadelphia has experienced an increasing number of young children in the early grades unable to behave as expected in class. It is in the interest of the schools, from a fiscal perspective as well as from the child's best interest, to actively assist in the prevention, identification and treatment of mental health problems of their students.

"The schools are not doing enough to help our children with their mental health problems, but that is where the treatment has to be because that is where they spend most of their time. We need to get in there, but there are so many barriers"

- A Provider

Schools are uniquely positioned to act as points for early identification of youth with mental health needs and are increasingly important direct providers of services. Services provided through Philadelphia schools include the Student Assistance Program (SAP) which assesses adolescents for drug and alcohol and behavioral problems, Consultation and Education Specialists (C & E) who work with children and their families to help counsel and connect them to school and community mental health resources, and Therapeutic Staff Support (T.S.S.) who often offer one-on-one assistance to children. In addition, some schools contract with outpatient mental health facilities to provide a therapist in a school-based mental health clinic.

Even with these programs, the predominant culture in schools and in the mental health system does not facilitate easy interaction or collaboration. Providers report that many schools treat existing programs as supplemental and separate services, and do not give mental health services high priority. In order to better serve children, the school system and the behavioral health system must develop more integrated infrastructures.

A City/School District task force established as part of the 2000 Mayor's Summit recommended the development of a three tiered system that would bring together representatives from the health, social service and schools systems to assure that services were being provided to children appropriately. The report was completed when the school system was in crisis and has been presented to the new chief executive of the School District. The City and the school leadership are working to develop improved, systemic coordination and interaction, but there is much improvement needed.

Consultations and Education Specialists

> *"I interact with these kids everyday and build relationships with them. So many of them are ignored when they have important things to say. When you have a relationship with them and care, then they come to you and tell you what is happening and you can get them help. I am able to see that what I do makes a difference."*
>
> *- A Consultation and Education Specialist*
> *Philadelphia Public Schools*

In the last decade, a new group of professionals, based in schools and charged with linking children and families to mental health services and supports has been introduced. Consultation and Education Specialists (C & E's), according to school leadership, advocates and providers, are now an integral part of the mental health system. Last year, there were 65-70 C & E's working in 119 of Philadelphia's 265 schools. There is widespread agreement that increased numbers of C & E's are needed to work with children and their families to connect them to needed mental health services and prevent the escalation of mental health problems. The new CEO of the School District has pledged to work with the City to place C & E's in all schools. While the C & E program was initially started with BHS funds, it is now supported through a combination of TANF dollars and school funds.

We spoke with these C and E's who urged better communication between parts of the child-serving systems. According to several C & E's, children are discharged from mental health facilities (hospitals and residential placements) with no plan for re-entering public school life. Too often they were left out of any assessment of the children's problems or treatment planning. One C & E said, "We often try to call our kids' therapists to explain what we have been seeing. I mean we see these kids everyday. And yet they (therapists) never call back because they are too busy."

The C & E's noted that even with their assistance, children were often forced to wait many days or weeks for outpatient appointments and that when children received an intake appointment they often waited again to be assigned a therapist. One C & E said, "While kids are waiting, we do the best we can to monitor them and talk with them about what is happening. But many of these kids need treatment and they need it now."

One principal of a middle school spoke so highly of the role played by C & E's in the school that she volunteered to teach several classes in order to save money to assure the on-going presence of a C & E in her school.

The Student Assistance Program

There are two Student Assistance Programs (SAP) in middle and high schools in Philadelphia. One works primarily with adolescents at risk for drug and alcohol abuse and is paid for through the Coordinating Office for Drug and Alcohol Abuse Programs (CODAAP) while the other one works with adolescents in need of mental health treatment and funded through the Office of Mental Health (OMH). Although it is widely believed that both SAP programs refer adolescents to the mental health system for treatment, we have focused on the OMH-funded SAP program which specifically works on mental health issues.

The SAP providers usually are [masters' level] mental health professionals whose purpose is to work with a team of staff at the school (usually school counselors and teachers) to assess adolescents and connect them to needed treatment. Similar to C & E's, SAP workers officially do not provide treatment to students. Philadelphia's Behavioral Health System contracts with four agencies, Einstein, Hall Mercer, MCP Hahnemann and Northwestern Human Services to provide mental health SAP services in middle and high schools. Last year ('01-'02) ten full-time equivalent SAP providers worked in 75 schools. They provided assessments for 800 students.

As recently as three years ago, SAP was unable to keep current because of large numbers of referrals. Within the last year however, referrals to SAP have declined significantly. Some providers have suggested that the way school staff are supported in this work has changed (school staff used to receive financial compensation for being a part of the SAP team, they no longer do), which has caused the decline in referrals to SAP. Providers now feel schools are not carving out time or space for SAP assessment meetings to occur.

The School District is planning to expand its SAP workers to more schools this year. In fact, a new resolution passed in October 2002 by the Philadelphia School Reform Commission (SRC) increases the number of SAP providers so that each middle and high school will have a SAP worker on-site one day a week.

Outpatient Therapy in Schools

In an effort to ensure that comprehensive, appropriate mental health services are available to all children who need them, many schools across the country are creating school-based outpatient mental health clinics. Mental health providers and advocates report that the State licensure procedure for school based clinics is cumbersome in Pennsylvania, but there have been some recent successes.

Seven agencies in Philadelphia have school-based satellite clinics. Unfortunately, utilization of these clinics has been low with only 330 children served in the 2001-2002 school year. While there may be families who do not want to receive certain services in schools, the reason for low utilization rates identified by providers with whom we spoke were: lack of awareness, and therefore lack of referrals on the part of school personnel, and problems coordinating services between the mental health system and schools. Providers who offer outpatient services in schools complained that school personnel often have no idea that therapy is available on-site. Without referrals from the school personnel, on-site clinics are unable to build a patient base. One provider interested in offering school-based services said, "We want to go where the kids are because that is where we can reach them, but if the school is too busy to work with you, then you have a therapist with no business. No one is going to do that because their paycheck is based on how many kids they see."

While acknowledging the problem of low utilization, most providers and advocates interviewed by PCCY agreed that school-based clinics were an important way to deliver services to children and adolescents. They identified many barriers to establishing and running such clinics, including the difficulty of obtaining a license in a timely manner. Providers who expressed interest in offering outpatient services on school grounds said they were unable to obtain the appropriate license. In addition to difficulties obtaining licenses, providers said another barrier is a new state law that requires a psychiatrist to be on-site a minimum amount of time. This requirement makes establishing a school-based clinic more difficult considering the inadequate numbers of psychiatrists to cover the current outpatient facilities.

The City/BHS and School District should:

- **Create a collaborative, coordinating structure to oversee mental health services in schools and to improve relationships and communications between schools and the mental health system.**

The State and City should:

- **Simplify the licensing process thereby increasing the number of licensed mental health programs able to conduct school-based assessment and therapy.**

The School District should:

- **Work with the City to establish a preferred provider network to contract with schools or groups of schools, to reduce confusion, improve accountability and increase students' access to services.**

Emergency System

Provides Crisis/Emergency Services with Safety Plans and Family Support

***Vision* - The behavioral health system should be able to support one emergency room to handle the mental health pediatric emergencies for children whose health care is provided by Medical Assistance. The emergency room should be able to handle all cases, referring those non-emergent care patients to outpatient and referring emergent care patients to inpatient care appropriately.**

***Reality* -The City's one emergency room is overused, crowded, and too small. The demand is ten times more than anticipated; patients often wait for long periods of time to be seen. The facility is too far for many to access and is not attached to an inpatient mental health facility for youth. The current emergency service is unable to meet demand.**

Some children enter the mental health system in a crisis of some sort, often through the emergency room or through another crisis service. The purpose of the emergency room is to work with children and adolescents in crisis to stabilize them and ensure appropriate aftercare. These crisis services can require an involuntary commitment or a visit from the Mobile Emergency Team (MET) to assess the problem and determine next steps.

Einstein Emergency Center

Although there are five mental health crisis centers located in the City, only one, located at the Albert Einstein Medical Center in the northern section of the City, is funded to serve children on Medical Assistance. Administrators at Einstein stated that privately insured children occasionally come to Einstein, but that the majority of their patient volume comes from uninsured children or children from neighboring schools.

Long Waiting Times and Insufficient Space at the Emergency Room

Einstein's Children's Emergency Service was created to see approximately 300 children a year. Instead, 2,768 kids were seen at Einstein in 2000 and 3,101 kids were seen in 2001 - ten times the original expectation. This increased utilization results in Einstein staff being overwhelmed by demand and children waiting for long periods of time to be diagnosed, treated and referred to the next level of treatment.

> *"I waited almost overnight to have my child seen in emergency. There was no place to be. We were on the floor."*
>
> *- A Parent*

While there has been improvement in the last few years, BHS estimated that on average children spend more than six hours in the emergency room. Many people PCCY interviewed thought that estimate was too low and did not accurately reflect the experience of children at Einstein. There is agreement among all with whom we spoke that children often wait long periods of time for care or placement. The waiting time prompted one provider to say, "We try to handle the crises that show up at our door because Einstein is always overloaded." The people PCCY interviewed mentioned other reasons for the long waiting times including an inadequate supply of hospital beds for children in need of acute care and inadequate numbers of ambulances to transfer youth once a bed is found.

Providers also reported that children in need of drug and alcohol treatment were often forced to wait an hour longer to receive treatment than other children because it is even more difficult to secure substance abuse treatment openings than those for mental health treatment. Finally, some people expressed particular concern for children in foster care because of traditional issues of consent, e.g. trying to locate parents or guardians.

Space and Emergent Care

> *"While waiting for treatment for my toddler's broken arm at the Einstein emergency room, I saw a nine year old boy brought in by police in handcuffs. I wondered what a nine year old had done to require handcuffs in an emergency room."*
>
> *- A Parent*

In addition to long waiting times, most people agree that space in Einstein's emergency department is inadequate. The children's crisis center consists of a small waiting area and two consultation rooms and is housed next to the adult crisis center. There are often many children waiting to be seen, and many children waiting to be transferred somewhere else for inpatient treatment since there is no inpatient mental health care at Einstein for children.

How Children Receive Crisis Treatment

Many children who are sent to Einstein during the week are sent from schools where they are involuntarily committed (known as "302'd"). An involuntary commitment means that a child is considered a danger to him/herself or others and requires a psychiatric evaluation. In school, if a child is disruptive or shows signs of a mental health emergency, the teacher or principal who witnesses the incident can call the police or OMH's Acute Services Division to request a commitment for the child. If the commitment is approved, the child is transferred to Einstein for evaluation in a police car (for children under the age of 14) or a police van (for children over the age of 14). It is up to the individual officers whether or not to handcuff the child.

If an involuntary commitment is denied, the Acute Services Unit will send out the Mobile Emergency Team (MET) to assess the problem and determine next steps. The MET is available 24 hours a day and is able to travel to all parts of the City. BHS reports that the Mobile Emergency Team made 786 contacts with kids in 2000 and 865 contacts with kids in 2001 and usually arrived at the school or house of a child in less than two hours. BHS reports that the MET frequently gets dispatched to schools. Between April and November 2001, 149 visits were made to 107 different schools. Some advocates complained that there is no one on the MET specially trained to work with children. They urged the need for a special children's MET with representatives from DHS and CODAAP on board along with a nurse specializing in pediatrics.

In addition to dispatching MET, Acute Services can send a Crisis Specialist to sit with a child for a few hours or days if he or she is not committed, but obviously needs help. Similarly to MET, the average waiting time for a Crisis Specialist is under two hours. Crisis Specialists were sent to see children 88 times in 2000 and 114 times in 2001. Advocates and BHS recognize that many children who experience crises are not in need of long term inpatient care or residential programs. Instead they may need short-term respite care. This type of stabilizing care is currently not available in the city. BHS has expressed interest in creating an eight-bed crisis residence for children with a maximum stay of five days.

After the Emergency

Regardless of which crisis treatment a child receives, he/she should eventually be referred to another part of the mental health system, usually to either an acute hospital or to the outpatient system. There was general agreement that the emergency system needed to do a better job of connecting children to treatment but that it was an uphill battle because of the long waiting list for outpatient services.

> *"Kids are sent from the emergency room with nothing but a number of a place that will put them on a waiting list."*
>
> *- A Provider*

If the psychiatrist at Einstein's emergency room determines that a child is in need of inpatient hospitalization, the doctor can require treatment for up to five days. The child or caretaker, depending on the age of the child, can also freely choose to be hospitalized, removing the need for commitment. Once it is determined that the child needs to be hospitalized, he or she will usually be transferred to one of the area psychiatric hospitals.

According to BHS and Einstein, approximately 25% of all children who come to the CRC are not true emergency cases. This number and its implications are very much in dispute. Many providers question the relevance of the classification since it is important for a patient to be examined to determine whether there is an emergency; others see the emergency room as being overused by the City's underfunded schools, or by others who think it would make it easier to get an outpatient appointment if referred by the emergency room staff. For those children, as well as other children not deemed in crisis, staff at the emergency center is supposed to give a family member or adult caretaker the number for BHS and tell them to call for a referral to an outpatient provider in their area. As was discussed earlier, these outpatient facilities often cannot see the children quickly.

The City/BHS should:

- **Establish a second mental health emergency room for children (run by another health provider) in another region of the City.**
- **Increase reimbursement rates for outpatient services to decrease waiting times for services so that children can receive more expedient on-going care.**
- **Provide children leaving the emergency room with connections to an outpatient treatment facility- all children should have next step in place (appointment with a therapist, bed in hospital etc).**
- **Communicate treatment plan or next steps/appointments with child's school principal, primary health provider and/or person who recommended the child to the emergency room. This communication can help ensure necessary appointments are made.**
- **Create a short-term respite, residence for children.**

Einstein should:

- **Increase the emergency room space for children.**

The School District should:

- **Increase schools' capacity to identify mental health emergencies, to develop treatment collaborations for children needing non-emergent care and to work with children with mental health problems.**

Inpatient Hospitalization

Provides Clinical Treatment and Family Support

***BHS's Vision* -When a child needs inpatient treatment, the treatment should be as connected to the other parts of the system as possible. Inpatient treatment should be connected to a mental health emergency room to expedite treatment. Sufficient numbers of inpatient beds should be available for children and adolescents who are experiencing a significant emotional or psychological crisis which may be life threatening to themselves or others. Once they have received appropriate treatment, patients should be connected to the next level of care, whether it is reintegration into the community with outpatient treatment, a partial program or a residential facility.**

***Reality* - Coordination of services between inpatient hospitals and other parts of the mental health system is inadequate. Philadelphia's mental health emergency room for children with Medical Assistance does not have children's inpatient beds, so children are often forced to wait hours before being transported to another hospital. Hospitals release children into the community without appropriate supports in place such as an outpatient therapist or adequate medication. Some children in need of residential placement languish in hospitals because no residential treatment facility will accept them.**

Inpatient hospitalization is an important aspect of clinical treatment for those children in crisis who are risks to themselves or others. It is the most restrictive and the most expensive service in the children's mental health system, costing thousands of dollars a day.

Approximately half of the children seen at Einstein for an emergency need inpatient treatment. According to BHS encounter data for 2001, 2,165 children and adolescents between 0-21 years of age were hospitalized for a mental health problem at a cost of over $29 million.

There are eight inpatient hospitals for children and adolescents in the Philadelphia area: Belmont, Devereux, Fairmont, Friends, Foundations Behavioral Health, Horsham, Progressions and Eastern Pennsylvania Psychiatric Institute, all of which accept both children and adolescents. Three of the eight hospitals that accept children are located outside of Philadelphia, which may make it difficult for families to visit. The three major children's hospitals in the region do not have contracts to provide inpatient mental health treatment to children on Medical Assistance, although they do treat the physical health needs of these children. There are some providers who believe separate hospitals for behavioral health treatment leads to further fragmentation of the health care system. As one provider said, "Why do we have to send our kids to another county when we have three premier children's hospitals in Philadelphia? These kids are away from their doctors, their families, their supports." It has been suggested that if children received inpatient treatment in the same hospital where they go for their physical health needs, primary care providers would remain more informed of their patient's complete well-being.

Physicians can involuntarily commit children and adolescents to a psychiatric hospital for up to five days, after which the doctor must petition the court to hold the child. According to interviews at inpatient hospitals, the staff encourages children and/or their families to voluntarily commit to treatment rather than force children to stay. Adolescents over the age of fourteen can voluntarily commit themselves for treatment, while children under fourteen must rely on their parents or caretakers to sign for them.

The length of stay for children varies widely from just a few days to many months. The number of days spent inpatient is influenced by how long it takes to stabilize a child, but also by how many days are permitted by a child's insurance plan. In general, many commercial insurance plans emphasize relatively quick discharges regardless of the doctor's recommendations. BHS, on the other hand, received praise for allowing children to stay until doctors felt they were sufficiently stabilized.

Finding a Hospital Bed

Although there is not agreement as to whether or not there are adequate numbers of inpatient beds, many providers complained about the difficulty of finding beds for children and adolescents in need of hospitalization. According to one physical health provider at a hospital, "We have to put children into our hospital to stabilize them and then transfer them to a mental health hospital when a bed can be found - but that can sometimes take days." For those children who present at Einstein for an emergency, the difficulty of finding a bed at a psychiatric hospital can result in a long wait at the emergency room.

No Hospital beds for children with medical and psychiatric problems

> *"We need hospital beds for children who have serious physical health and mental health problems. If it was an adult, we would have a place to treat them, but children have no where to go. As a doctor I am often forced to choose which problem is more important when, what the child really needs is both."*
>
> *- A Provider*

Med-psych units are located in hospitals and are set aside for people experiencing medical and psychiatric problems. They are needed because typically mental health hospitals are not able to manage complicated or significant physical health problems. Examples of children who would need this type of care range from a child whose severe depression has interfered with management of his diabetes to a child who was injured in a car accident and is experiencing extreme post traumatic stress syndrome. Med-psych units are needed, because they can treat both the medical problems (usually because they are attached to a medical hospital) as well as managing the behavioral/psychiatric problems. Adolescents 16 or older in need of a med-psych bed are sometimes able to go to an adult unit, but there is not a single med-psych bed available in the City for children.

After Leaving the Hospital

> *"Whenever he would leave the hospital he would come back and be fine for a few days, but without his help [T.S.S and mobile therapist] he would just go back to not doing well and the cycle began again"*
>
> *- A Parent*

In interviews with providers and advocates PCCY staff did not hear many complaints regarding the treatment children receive at inpatient facilities. Instead, the main problem appears to be the lack of coordination between inpatient care and other parts of the mental health system. When children leave a psychiatric hospital they are sent to one of three parts of the system: a residential treatment facility, a partial program, or the outpatient system. The people we interviewed at hospitals felt the other parts of the system, particularly the outpatient system, were unable to adequately support children when they are discharged. One provider said, "No one wants to invest in the long term health of kids. We just stabilize kids and send them back out into a system that is incapable of dealing with them."

Other providers said, “Patients don’t have appropriate resources when they leave the hospital, so they leave stabilized, but do not remain stable - they then end up back in crisis.” One psychiatrist spoke about an adolescent who had been hospitalized five times over two years. This psychiatrist said, “We are failing these children by sending them back without appropriate supports.”

The City/BHS should:

- **Assess the adequacy of current inpatient beds for children and expand capacity as necessary.**

- **Increase the number and quality of post-discharge services such as outpatient care to support children after discharge.**

- **Improve coordination between inpatient hospitals and all other parts of the behavioral health system.**

- **Establish a med-psych unit for children in Philadelphia.**

Residential Treatment Facilities

Provides Clinical Treatment and Family Support.

***Vision* - Residential treatment facilities should provide quality intensive therapeutic services, round-the-clock supervision and prepare patients for returning to their homes and schools.**

***Reality* - Residential treatment facilities are often difficult to secure, particularly for the most aggressive or "difficult" kids. These children often wait months in hospitals for placement and frequently have to be sent out of the State or region. The completeness of the discharge planning and preparation for return home varies markedly.**

Residential treatment facilities (RTF's) are designed for children who need ongoing, round-the-clock supervision and intensive therapeutic services. The clinical treatment available at RTF's include individual and group therapy, special schools with therapeutic classrooms and psychiatric evaluations and treatment. Usually children who need residential placement are sent there from an inpatient hospital. In 2001 BHS reported that 1,488 children and adolescents ages 0-21 received treatment at a residential facility. The 15 RTF's that serve the majority of Philadelphia children are:

Name	Location	Age
Silver Springs	Plymouth Meeting	6-14
Wordsworth	Ft. Washington Chalfont Shawnee Elkins Park	14-1 5-14 13-2 5-18
Presbyterian Children's Village	Rosemont	13-1
St. Mary's	Ambler	4-10
St. Francis	Bensalem	11-1
Westmead	Warwick	13-1
Bethanna	Southhampton	5-15
Crestwood	Langhorne	6-18
Deveraux	Glenmoore, Newtown Square West Chester Malvern	5-17 9-17 10-1 10-1
Elwyn	Media	8-17
Foundations	Doylestown	14-2
Mentor Homes	Conshohocken	3-19
Path	Philadelphia	12-1
New Directions	Philadelphia	8-21
St. Josephs	Bensalem	8-11

Even with this list, most advocates and providers we spoke with felt that there were inadequate residential options because: (1) there are inadequate numbers of beds in the region, particularly for young children. While the reason for the lack of such facilities may be a matter of dispute, with some arguing that low reimbursement was the cause and others citing Pennsylvania's rule against locked treatment facilities, there is agreement that the small number of facilities has negative results. (2) Instate facilities can pick and choose children arbitrarily. (3) Many local youth are sent far away to secure treatment.

Many providers and advocates reported that the determination of which patients a facility will accept is made without interviewing individual children. In addition, our sources stated that RTF's often do not tell the hospital or the child why he/she was denied admission. For this reason, providers said that it can take months to find an RTF placement for a child, particularly for an extremely aggressive one. If a child is rejected from every RTF in the State, hospitals have to send the most aggressive kids out of state, usually to Texas, Virginia or Oklahoma. Children are also sent to other states such as Texas because RTF's there are allowed to have locked facilities.

Even when a child is placed in a local RTF, only two of the facilities listed above are located in the City. This makes it difficult to impossible to offer family therapy and is a burden on many families who wish to visit their children. Some parents reported taking three or four busses to visit their child at a residential facility, while others said they were not able to go as often as they would like because of the distance.

As noted with all other areas of the mental health system, coordination between and among parts of the system is lacking. This can mean that children are released from residential treatment without adequate supports in place to integrate them back to their home and school life. One parent expressed her concern about her child returning from a residential placement by saying, "I am nervous because he only does good when all of his services are in place. They keep saying it will be okay but it worries me." One complaint from staff and administrators at residential treatment facilities regarded the lack of connection between residential treatment and schools. One provider said, "When they (children) leave here they have an IEP [Independent Education Plan], but the school district often doesn't care and doesn't even look at it. These kids are dumped in special education or a regular class and the problems they had before they entered treatment return."

The City/BHS should:

- **Develop more residential treatment facilities in the City for children of various ages and various needs.**

- **Emphasize the importance of discharge planning to ensure children have adequate supports before they are discharged from residential placement.**

Residential treatment facilities should:

- **Increase communication and coordination between RTF's and other parts of the mental health system and other child-serving systems.**

- **Provide families and doctors with explanations when children are denied admittance to their facility.**

Day Treatment/Partial Programs

Provides Clinical Treatment and Family Support

***Vision* - Day treatment programs should be made available to serve children who require more attention than traditional outpatient services in order to prevent residential placement and hospitalization and to assist children transitioning home from these more restrictive environments.**

***Reality* - Philadelphia has too few day treatment programs to prevent children's problems from escalating. Many of the existing programs are disconnected from the rest of the outpatient system, resulting in children leaving a day treatment program without a firm treatment plan in place.**

Day treatment programs are designed to serve children who are living at home and who require more attention than traditional outpatient services can offer, but who do not need a residential program. Partial programs can also be used to help transition a child back into the community from a residential placement or hospitalization. The clinical treatment available at day treatment programs include individual and group therapy and therapeutic classrooms.

Philadelphia has both long-term (from one month up to a year) and short-term (one to three weeks) partial programs. According to BHS encounter data for 2001, 2,542 children under 21 received treatment from a partial program. According to people interviewed for this report, partial programs are an important aspect of the mental health continuum of care and are essential for children leaving residential facilities. Unfortunately, these same people expressed concern over the small number of partial programs in the City. Many providers told us that they had either attempted to open or actually opened a partial program, but closed the program because of inadequate reimbursement rates.

Advocates for children and adolescents who receive partial care are concerned that the facilities that run partial programs are often disconnected from the rest of the outpatient system, which can result in children leaving a partial program without a firm treatment plan in place. One advocate who works in the Philadelphia public schools said, "Children are discharged from partials and come back to school with nothing. Then people act surprised when the child is expelled or ends up back in the system. They are not getting the support they need."

Both the schools and the mental health system must assure that children receive the programming and the education they need. In addition to the problem of supporting children and adolescents when they leave partial programs, legal advocates have been exploring the problem of children and adolescents in partial programs missing school, sometimes for long periods of time, in order to attend a partial program.

The City/BHS should:

- **Develop more day treatment programs for children of different ages.**
- **Enhance discharge planning so children leave day treatment programs with appropriate supports.**
- **Develop more school-based day treatment and other therapeutic programs in schools.**

Needed Data

The Mental Health System for Low-Income Children

Needed Data

Decisions are being made anecdotally. We need clear standards about quality and adequacy of supports and treatment. We need better information to assess and evaluate our own performance and that of the system.

Although BHS was very cooperative in providing us with data for this report, significant utilization information is lacking. Determining whether or not a system has the capacity to handle the number of people who need services is complex. More comprehensive data would help us build a framework to better understand where resources are needed and how services should be reshaped.

For example, we were unable to estimate how many individual therapists or psychiatrists accept children on Medical Assistance. Without this information, we are unable to calculate a child to therapist or psychiatrist ratio, which could help us better understand the capacity problems of the outpatient system. In addition to needing data regarding the number of providers, we were interested in further untangling the issues surrounding inpatient capacity. As stated in the chapter on Inpatient Hospitals, advocates and providers consistently cite a shortage of inpatient beds for children as a problem. BHS, on the other hand, states that there are adequate numbers of beds and children are not forced to wait. While we understand that collecting information on the number of inpatient beds is difficult (the number constantly changes and some beds are being used by children with private insurance), even point of time data would be helpful. Comparing the number of available beds with the number of children who receive inpatient treatment would help us understand and provide direction towards solving this complex problem.

There is similar confusion regarding the adequacy of capacity at area residential treatment facilities (RTF's). Again, having data on the number of slots would help us better understand the issues around residential facilities.

Finally, another concern expressed by advocates and providers was that children are routinely turned down by RTF's when they need residential treatment. Officials from BHS agreed that this has been a problem, but they do not keep records on the number of acceptances and denials. PCCY recommends tracking this problem by keeping records of the number of children who are denied a slot at an RTF so that we have a better understanding of the problem and can track whether or not improvements are being made.

A Closer Look: Wraparound

The Mental Health System for Low-Income Children

A Closer Look: Wraparound

Although this paper's primary focus is on the different parts of the mental health system, each part is made up of individual services. Because of this, we have chosen to take a closer look at one service, wraparound, to highlight the problems discussed in the Outpatient chapter and to hone in on improving what has, perhaps, become the most debated mental health service for children.

***Vision* - Quality, accessible services for children and adolescents must be available so that they can be maintained in their schools and homes.**

***Reality* - In Philadelphia, these services have been called wraparound. They are frequently uneven in quality, uncoordinated, and used, in many instances, because they are accessible and not because they are the treatment of choice.**

What is wraparound?

Wraparound grew out of a nationwide effort in the 1980's to reform children's mental health services which had been recognized as too restrictive, insensitive, inefficiently organized and poorly targeted to meet children's needs. Before the emergence of wraparound, children were served by a system created to meet the needs of adults with mental health problems. Wraparound was the first service model specifically geared towards the special needs of children.

Rather than being built upon a set of programs or services, the theory of wraparound required creating an individualized care plan for each child with a mental health problem. The plan was supposed to be community-based and grow out of the strengths, values, norms, and preferences of a child and his/her family. Although against the original philosophy, wraparound as it has been practiced in Philadelphia has become synonymous with a set of three services: Therapeutic Staff Support (T.S.S.), Mobile Therapy and Behavioral Specialist Consultation. In fact, many people PCCY interviewed thought of wraparound as synonymous with only one service: T.S.S. T.S.S. is supposed to involve an intensive one-on-one mental health worker for children at risk of residential placement or hospitalization to provide individualized services, encouragement, behavior modification, crisis intervention and other services to children designed to offer support and structure to the family in order to maintain a child in the community setting.

Explosion of Wraparound

In the last decade, wraparound services have grown exponentially as more restrictive services have been considered less desirable and other community-based settings have become inaccessible. The growth is thought to have occurred for many reasons including: because the services have been viewed as providing reasonable reimbursement rates in comparison with outpatient services, providers turn to T.S.S. to help pay for other outpatient services; because they provide another pair of hands and eyes in difficult school and home settings, and because they have been easier than other services to secure.

Wraparound services vary widely in quality as well as in supervision and staff development. Concern about the rapidly increasing cost of the service has generated anticipated cutbacks while demands for more and better wraparound services have also been the subject of several lawsuits. These lawsuits have resulted in requiring more staff training, less waiting time for children to receive services and substitutes T.S.S.'s for schools when the usual provider is absent. Each of these outcomes may have an unexpected impact on service delivery.

According to providers interviewed by PCCY, the increasing numbers of children receiving wraparound was a result of two factors: (1) the reimbursement rate for wraparound was relatively higher than the rates for other outpatient services, and (2) wraparound was sought after by parents and providers because it provides immediate, concrete help to kids.

When speaking about wraparound, service providers and advocates in Philadelphia said:

"Wraparound is the only service that is adequately reimbursed - providing traditional outpatient services does not allow a clinic to stay open. The main reason that wraparound has grown so quickly is that it is the only one with decent reimbursement rates."

"Increase outpatient reimbursement and it will decrease wraparound costs."

"Provider agencies lose money with outpatient services. We need higher reimbursement rates or the incentive is to focus on wraparound."

"Reimbursement rates for outpatient care haven't gone up in nearly 10 years, how can we afford to not offer wraparound?"

Finally, many people expressed concern that wraparound has become a method for controlling children who are disruptive in school, rather than a therapeutic service. One children's advocate said, "Schools like wraparound/T.S.S. because it helps with discipline in the classroom."

The failure of the educational system and the rest of the outpatient mental health system to adequately address the needs of children with mental health problems created a dramatic increase in wraparound utilization. Because it was readily available, schools, parents, and providers all sought wraparound. As one parent said, "I don't know when it happened, but suddenly all I could get for - [my child] was wraparound but he needed something else."

Other Problems with Wraparound

Experience with wraparound is mixed. Some advocates reported classrooms in the City with numerous T.S.S. workers from different agencies, each assigned to a different child. Everyone with whom we spoke agreed that this was a waste of resources, led to waiting times for other students in need of services and created problems in the classroom. There are examples, however, of schools with preferred provider contracts, which have reduced the number of T.S.S. workers and led to better coordination of services.

In addition to concern regarding the expense of wraparound, there is much discussion surrounding the quality of service provided which varies depending on the agency providing T.S.S. workers. Perceptions of the quality of the T.S.S. differed greatly depending on the provider agency being discussed. Some therapeutic staff support workers have virtually no training while others are well trained and supervised.

Strategies to Deal with Wraparound

Although wraparound is sometimes the service that providers and consumers love to hate, wraparound is an important part of the mental health system and is the treatment of choice for some children. The problem is that it has been over-prescribed. In describing how a T.S.S. worker helped her son, one parent said, "He was destructive and didn't know how to act right. The T.S.S. helped him understand how he was supposed to act and he would listen to her. He always did much better when she was over." The solution is not de-funding wraparound, but exploring how strengthening other parts of the outpatient system and mental health services and supports in the schools can correct the dependency on wraparound and improve the wraparound delivery system.

In recognizing the problems, BHS is implementing two school-based wraparound pilot programs that are designed to try to correct some of the identified problems. The first pilot started in the fall of 2002 in six schools with high T.S.S. utilization rates. The program connects each school with a single provider agency to provide behavioral health specialists to that school; the specialists work together in teams to assist all of the children who may have needed T.S.S in the school. These teams serve up to 21 children at a time. The team pilot provides 90 days of service, rather than the current 120 days of authorization. After the 90 days, requests for extensions will be considered. If successful, the pilot will be expanded to include other schools in the coming years. The second pilot is being implemented in the Audenreid schools and is modeled after a program in Cleveland, Ohio. With this pilot, 30 children are receiving care in three therapeutic classrooms. After a thorough evaluation of these two pilot programs, decisions should be made regarding expanding the programs to other schools. The hope is that these two pilot programs will help determine how to offer needed services to children while saving the system millions of dollars which can be used for other needed treatment options.

The City/BHS should:

- **Establish a preferred provider system for all wraparound services in the schools allowing for coordinated services.**
- **Replicate the new model if it is successful.**
- **Increase reimbursement rates and capacity for other outpatient services so T.S.S. is not overutilized.**
- **Make T.S.S. available when considered medically necessary.**

The City/BHS and School District should:

- **Increase other mental health personnel and services in schools to help refer children with mental health problems to appropriate treatment.**

Conclusion

The Mental Health System for Low-Income Children

Conclusion

Philadelphia is developing a system to provide thousands of children from low-income families the mental health treatment they need. Many of the necessary pieces are in place, but much work remains. There are not enough qualified staff, not enough good programming and not enough accessible community-based help for children and families. We must seek solutions to attract and maintain qualified staff; build the capacity of the outpatient system; develop the processes that support coordination and collaboration between our schools, social services and the mental health system, and assure that the needed services are available when and where children need them.

In addition to the incremental steps outlined in this paper, PCCY recommends a new partnership between the many agencies and departments that are responsible for children's health and well-being to reform how mental health services are provided to Philadelphia's children. In particular, the educational and mental health systems must come together with a cross-agency structure to develop comprehensive, multifaceted, and integrated approaches for addressing students' behavioral health needs, barriers to learning and enhancing healthy development. This structure would also be ultimately responsible for ensuring that children and adolescents receive needed treatment regardless of whether it was through a school-based clinic, a Consultation and Education Specialist, a Student Assistance Provider or a school counselor.

Systemic changes must weave school and other community resources together to reshape how mental health services are delivered in schools and to ensure that children in need of services are connected to the larger mental health system. Children's mental health policy and practice, including the many categorical programs funded to deal with designated problems, should be woven into a cohesive continuum of interventions and integrated thoroughly with current school reform efforts.

Too often, we choose not to see or intervene until a crisis occurs. Too often, children cycle back and forth between hospital and the community without ever achieving prolonged stability. In turn, unnecessary hospitalization usurps the limited resources of mental health budgets.

> *"The real world we send kids back to isn't ready to support them and keep them on the right track."*
>
> *- A Provider*

But, with effort, it can be.

Acknowledgments

The Mental Health System for Low-Income Children

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A Project of
Philadelphia Citizens for Children and Youth

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