Chairman's Letter

The mental health of our children and youth is too often misunderstood, just assumed or ignored. That is until there is some tragic event such as the Sandy Hook shooting or Columbine. In these circumstances there is a brief initial discussion about mental health but that is soon swallowed up in political debate over gun control. What obviously gets lost in all this is the why the tragedy occurred. Attention is not focused upon such items as accessibility to mental health services, the extent of social isolation the children experience, the potential bullying that took place, the lack of ability to understand and respond to warning signs by the parents, family members and the community and a host of other issues. The communities are quick to respond with grief counseling for children after the event but are slow, limited or unconcerned about the mental health and resiliency of the children before the event.

The system that exists for the care and treatment of individuals who do not display good mental health or who are exhibiting signs of mental illness is fragmented and to a large degree ineffective. This is in no small part because of a lack of coordination, a lack of training, a lack of parental involvement and a failure to recognize the totality of issues that surround and impact children and youth.

A major point that must be clarified before the community can begin to address the issue of mental health and resiliency in children and youth is one of definition. The US Department of Health and Human Services defines mental disorders among children as being "serious deviations from expected cognitive, social, and emotional development". The problem arises as to what constitutes serious as well what are the norms for cognitive social and emotional development. In an age when there is severe questioning of norms as a general concept and a greater emphasis upon the idea of tolerance, the matter of determining what behavior is serious enough to warrant some degree of intervention becomes highly problematic. Perhaps looking at the positive side, i.e. what is mental health may provide better direction for a course of action in the community. Mental health in childhood can be said to be characterized by the achievement of development and emotional milestones, healthy social development, and effective coping skills, such that mentally healthy children have a positive quality of life and can function well at home, in school, and in their communities. This too is not as well defined as it needs to be but puts the emphasis on strengthening the character and resiliency of children as opposed to solely intervening after something bad has happened.

A review of current literature indicates that attention-deficit/hyperactivity disorder is the most prevalent parent-reported diagnosis for children aged 3 to 17 years. The prevalence is

estimated at 12.1% for this disorder. This is followed by anxiety at 8.2%, depression at 5.4%, autism spectrum disorders at 3.7%, and behavioral or conduct disorders at 3.5%. Additionally the most recent Youth Risk Behavior Assessment report from the National Center of Disease Control, December 2011 indicates the rate of suicide attempts at 7.8%. A recent community survey showed that 8% of youth have thought about suicide at least once during a given year. That such a solution to stress or other problems is even thought of should be a sign that children are having issues dealing with their lives. Childhood or early onset schizophrenia is also very rare but is also highly devastating when it occurs.

There are signs and indicators for severe depression that would lead to suicide as well as certain behavioral signs that would indicate the onset of schizophrenia that could result in an earlier intervention and mitigation of some of the devastation caused by both these conditions. All too often parents, teachers and friends either ignore the signs, are not aware of what they are seeing and even if recognized may not wish to get involved or know how to get involved. If such dramatic problems are being overlooked, how much more are the more subtle issues of social withdrawal, feelings of isolation, and depression not being seen or addressed? Parents, peers, and institutions are often not engaged, do not have the skills, or lack the capacity to proactively address developing mental health and resiliency in children much less to address significant problems when they arise.

Mental health resiliency and treatment for mental health issues does not rest with a singular agency or program. For our community to have mentally healthy children, youth, and adults requires a multifaceted approach that is integrated, forward looking, and nimble when needs are identified. To accomplish this there must be an alignment of goals and approaches that will facilitate mental health and resiliency from pre-birth through the teenage years. Parental involvement, especially involvement of fathers, must be enhanced. Equally as important is that parents are provided with the supports they need to be successful and have assistance navigating an overly complicated system for their children. Skills relating to developing strong mental health and dealing with problems must be taught to parents, physicians, nurses, teachers, and peers. When there are issues the parents must be able to quickly find assistance that is effective and compassionate. This may appear to be a daunting task but it need not be if we as a community are committed to the goal of mentally strong children, youth and young adults. A valid survey of community indicates that there is understanding and support. Motivating people to act becomes the real challenge. It may appear that many more dollars will be needed to do this. This may not be true. We know that what we have now is fragmented

and in many ways duplicative. It is therefore inefficient. The resources that will need to be added will best be determined once there is a better alignment of effort. To do this will require an ongoing group of citizens who are willing to put in the time to bring change to the system, to work with the schools, the mental health community, the insurers, juvenile justice and other agencies along with parents to bring accountability and enhanced capability to our community in this most vital of areas. It will take a commitment to refocus on how we as a community, as a society interact with our children to help them become strong and to be there to make sure that there is help for families and children when real issues arise.

On behalf of the Orange County Youth Mental Health Commission I am pleased to submit this initial report. This is just the beginning of fulfilling the charge given to us by the Orange County Mayor. Our work will need to continue to solve the issues raised in the report and to help bring about better mental health in our children and youth.

Rich Morrison, Chair
Mayor's Youth Mental Health Commission

Orange County Youth Mental Health Commission

Richard Morrison
Regional Vice President/Chair
Florida Hospital
2400 Bedford Road
Orlando, FL 32803
Ph: 407-303-1607
E-mail: rich.morrison@flhosp.org

The Honorable Belvin Perry, Jr.
Chief Judge/Co Chair
Orange County Ninth Judicial Circuit
425 N. Orange Avenue
Orlando, FL 32801
Ph: 407-836-2042
E-mail: ctjubp1@ocnjcc.org

Polly Anderson
Executive Director
University of Central Florida/WUCF TV
12461 Research Pkwy, Ste 550
Orlando, FL 32826
Ph: 407-823-6112
E-mail: polly.anderson@ucf.edu

Maria Bledsoe
Chief Executive Officer
Central Florida Cares
707 Mendam Blvd, Ste 104
Orlando, FL 32825
Ph: 407-985-3560
E-mail: mbledsoe@cfchs.org

Sara Brady
President
Sara Brady Public Relations
222 W. Comstock Ave, Ste 215
Winter Park, FL 32789
Ph: 407-702-6632
E-mail: sbrady@sarabradypr.com

William Butler
Student
University of Central Florida
4000 Central Florida Blvd
Orlando, FL 32816
Ph: 407-744-2498
E-mail: WB1993@knights.ucf.edu

Dr. Michael Campbell, Ph.D, LCSW
Director of Patient & Family Centered Care
Nemours Children's Hospital
1717 S. Orange Ave, Ste 100
Orlando, FL 32806
Ph: 407-650-7493
E-mail: michael.campbell@nemours.org

Glen Casel
President
Community Based Care of Central Florida
4001 Pelee St, Ste 200
Orlando, FL 32817
Ph: 321-441-2060
E-mail: glen.casel@cbccfl.org

William D'Aiuto
Regional Managing Director
Florida Department of Children & Families
400 W Robinson St., Ste S1129
Orlando, FL 32801
Ph: 407-317-7054
E-mail: William_s_daiuto@dcf.state.fl.us

The Honorable Jerry Demings
Sheriff
Orange County
PO Box 1440
Orlando, FL 32802
Ph: 407-254-7000
E-mail: jerry.demings@ocfl.net

Orange County Youth Mental Health Commission

Dr. Karen Hofmann
Director, Counseling/Psychological Svcs
University of Central Florida
UCF CAPS, PO Box 163170
Orlando, FL 32816
Ph: 407- 823-2812
E-mail: karen.hofmann@ucf.edu

Dr. Barbara Jenkins
Superintendent
Orange County Public Schools
445 W. Amelia St.
Orlando, FL 32801
Ph: 407-317-3209
E-mail: barbara.jenkins@ocps.net

Muriel Jones
Executive Director
Central Florida Federation of Families
257 Fernwood Blvd, Ste 101
Casselberry, FL 32730
Ph: 407-929-3133
E-mail: murieljones.ymhc@gmail.com

Cathy Lake
Acting Chief Probation Officer
Florida Department of Juvenile Justice
8500 Laurel Hills Dr
Orlando, FL 32818
Ph: 407-445-5354 x300
E-mail: cathy.lake@djj.state.fl.us

Dr. Mike Muszynski
Associate Dean for Clinical Research
Florida State University
250 E. Colonial Dr, Ste 200
Orlando, FL 32801
Ph: 407-835-4103
E-mail: michael.muszynski@med.fsu.edu

Table of Contents

Mayor's Youth Mental Health Commission

Final Report
2014

ORANGE COUNTY GOVERNMENT
FLORIDA

"Come Together
Work Together
Meet the Need"

Orange County Mayor Teresa Jacobs

Youth Mental Health Commission

Final Report

2014

Respectfully Submitted by the Committee Workgroups

Needs Assessment
Glen Casel, Chair

Impact of Violence
Carol Wick, Chair

Systems Design
Bill D'Aiuto, Chair
Muriel Jones, Co-Chair

Public Awareness & Community Education
Sara Brady, Chair

Finance and Sustainability
Jerry Kassab, Chair
Maria Bledsoe, Co-Chair

Come Together, Work Together...Meet the Need

Mayor's Youth Mental Health Commission
Executive Summary

As a result of tragedies around our country and the attention to issues surrounding mental health access in our County and State, Mayor Teresa Jacobs convened the Youth Mental Health Commission on August 26, 2013. The Mayors purpose was to convene a group of stakeholders, community leaders and consumers who would delve into system issues for children's mental health and address short and long term strategies for improvements to those systems meant to serve this vulnerable population. Richard Morrison, Regional Vice President of Florida Hospital and Chief Judge Belvin Perry, Jr., the Ninth Judicial Circuit quickly accepted the challenge of Chairing the Commission. The Commission members truly epitomized the brain trust, critical thinking and experience necessary for the task. Along with the Commission members an astounding 114 of affected family members, mental health professionals, and interested parties participated in the working committees.

The Commission recognized that the populations to be served by the proposed Youth Mental Health System of Care include those individuals from birth through age 24. Scientific evidence reinforces our need to pay attention to that range due to trauma en utero, exposure to violence, untreated symptoms and their effects of the onset of major mental health issues in children. Combined with the onset of mental illness for many children, and teens transitioning to adulthood, the range of 0-24 made the most sense.

The Commission established four working committees and one workgroup charged with reviewing local and national data and current practices and outcomes, of the youth mental health system in Orange County. These Committees had on-going meetings for six months with specific goals and objectives. The Committees were as follows:

- Needs Committee - Glen Casel, Community Based Care of Central Florida
- Systems Design Committee - William D'Aiuto, the Florida Department of Children and Families and Muriel Jones, Federation of Families of Central Florida
- Finance and Sustainability Committee - Jerry Kassab, Lakeside Behavioral Healthcare/Aspire and Maria Bledsoe, Central Florida CARES
- Public Awareness and Community Education Committee – Sara Brady, Sara Brady Public Relations
- Impact of Violence Workgroup - Carol Wick, Harbor House

Overview of Florida

Florida is currently ranked 49th in the nation in funding for mental health services. Orange County and the central Florida region is the 2nd lowest funded in the state, despite having the fourth largest child population in Florida, (Kaiser Foundation, 2013). Additionally, 2011 data indicates there were 210,885 persons living in poverty in Orange County and 69,633 were under the age of 18. According to the 2013 PRC Child and Adolescent Community Health Needs Assessment sponsored by Nemours Children's Hospital, 6.2% of families report having no coverage for their child's healthcare expenses.

Prevalence Data of types of Mental Health Disorders

It is estimated that 15 million of our nation's young people can currently be diagnosed with a mental health disorder that is causing significant stress and impairment at school and home. This means that about 20% of children (1 in 5) ages 8-15 have a diagnosable mental health or addictive disorder (U.S. Department of Health and Human Services, 2008). Some of the more common mental health disorders experienced by the child/youth population throughout the country include Attention Deficit Disorder with or without Hyperactivity, Depression, Anxiety disorders, Posttraumatic Stress Disorder, Oppositional Defiant Disorder, Conduct Disorder/Disruptive Disorders and Substance Use Disorders (American Psychiatric Association, 2013). Children, youth and young adults have differing needs based on their actual age and developmental age. Unfortunately, there is not a "one size fits all" approach that can be used across all ages.

Age of onset

National data indicates that 50% of all lifetime mental health disorders present by the age of 14 and 75% by the age of 24. From a developmental perspective when disorders present at an early age and are left untreated, the long-term negative impacts extend across the lifetime. Symptoms of mental health disorders appear much differently in children, adolescents and young adults, thereby presenting with a variety of diagnostic challenges for providers. The result is over-diagnosis and/or under-diagnosis of disorders, improper use of psychiatric medications, and problems at home, school and in the community.

Report Primary Findings

The primary message from the final report of the Youth Mental Health Commission is that Orange County has a system for Children's Mental Health and has a wealth of resources that present as unique opportunities on which to build. Unfortunately, the current system is fragmented, disjointed and almost impossible to navigate for parents and families and a complete system redesign is recommended. The results of this ineffective system negatively impact arrest rates, school suspension and expulsions, psychiatric hospitalizations, suicide rates, child welfare placements and other indicators that show the types of services and supports needed in our county are lacking.

Six major areas of need to be addressed in the system redesign project were identified. The factors overlap and interplay and together create a cycle of ineffectiveness. As a child and family move around the system the issues and challenges worsen. The six major areas of need identified are:

- **lack of system design or coordination,**
- **financing model disincentives and poor accountability,**
- **restrictive service array (wrong mix of services),**
- **system complexity,**
- **inadequate resources (prevention and intervention),**
- **and lack of system accountability.**

Final Priority Recommendations:

- Create Implementation Team
    - Implementation of Commission Recommendations by community leaders and stakeholders
- Create Management Network
    - Suggestion for a Management Network/Orange County to be the convener and leader for the Provider Network/Systems change driver
- Expand "System of Care" Network 0-24
    - State Reinvestment grant to begin to address immediately
    - 24 hour hotline
    - Expand and enhance early prevention and intervention
    - Expand Wraparound service delivery 0-24
    - Involving new fathers programs and parent support programs
    - Provide expansion of services for teens and young transitioning adults
- Create information system for easy navigation and service inventory (virtual "no wrong door")
    - A robust data system would assist with navigation and inventory management allowing families to get to the right door the first time
    - Creates a virtual central point of access for referrals and resources
- Blend and braid available funding from existing funding streams
    - Prioritize funding for evidence based and need based programs

- Coordinate with Medicaid/Managed Care Providers
- Incentivize outcomes
- Explore dedicated revenue for children's services

- Behavioral Healthcare navigators
  - Assist families navigating the system of care
- Children's Mobile Crisis - 24/7 Response
  - Keeps families and children together
  - Prevents arrests and out of home placements
- Children's Assertive Treatment Team (CAT)
  - Requesting funding in 2014 legislative session
- Utilize HITS tool (Hurt-Insult-Threaten-Scream) and Healthy Start screenings to screen for exposure to violence
  - Access to trained professionals with credentialing process
  - 24 hour access to trained professionals
- Community Training – Access to Mental Health First Aid training
- Public Awareness Campaign
  - Billboards, PSA's, Social Media
  - Corporate Partners
- Communication "Call to Action"

Overview of recommendations

The primary recommendation is the creation of a community structure to drive the strategic planning process needed for systemic changes. An "Implementation Team and Management Network" would provide the platform for the multitude of recommendations centering on accountability, credentialing and expansion of qualified clinicians, centralized intake and behavioral health navigation, in-depth assessment, care coordination using unified plans, use of evidence based practice, data collaboration and management, expansion of a the service array, a model for public awareness and community education forums to increase family support and advocacy, and increased accessibility for children, youth and young adults in our community. Monitoring of outcomes from a community perspective is key and a community dashboard is recommended to ensure the system changes positively impact Orange County. Finally, there are specific recommendations for improved financing of children's

mental health across the county. The "Implementation Team" would strategize and plan for creating a dedicated children's funding source as seen in other counties in Florida. Additionally, financing would be expanded through community collaboration for grant applications, working with the Agency for Healthcare Administration to increase the array of services funded by Medicaid, and outreach activities to educate managed care companies, to name a few. Specific recommendations for each area can be found in the final report and are too expansive to mention individually.

Conclusion

The recommended model for systemic change is the "system of care" approach which has re-shaped children's mental health services to the extent that at least some elements of the system of care philosophy and approach can be found in nearly all communities across the nation (Stroul, Blau, & Friedman, 2010). The approach has also been adopted by child welfare, juvenile justice, education, and substance abuse systems; early childhood programs; systems designed to serve youth and young adults in transition to adulthood; and even many adult-serving systems across the nation. Orange County currently has a "system of care" project titled Wraparound Orange. The project has provided a foundation for the types of changes needed in our community. Efforts of the Implementation Team and Management Network can be summed up by bringing the "system of care" to scale to encompass services for children, youth and young adults ages 0-24. The Youth Mental Health Commission has dedicated themselves to the changes needed in our community and has adopted the tagline: Come Together, Work Together.... Meet the Need.

Orange County Youth Mental Health System of Care

Mission: The Youth Mental Health Commission leads the implementation and monitoring of an effective children's mental health and substance abuse service delivery system that provides easy access, crisis response and diverse high quality services to children, youth and families in Orange County.

Vision: A community of resilient youth and families well equipped to deal with the stress of life and enjoy empowered, independent, healthy and productive lives.

Problems	INPUTS	ACTIVITIES	OUTCOMES	
County Child Data 2012-2013	**What we invest**	**Strategies to create change**	**Outputs**	**Objectives**
• 7,520 arrests for ages 0-17 • 2,250 felony arrests for ages 0-17 • 84 children processed in the Juvenile Assessment Center ages 5-10 (2012-2013). • School Suspensions equal 15,273 and 27 youth expelled, (2012-2013). • Aug-Nov 2013 over 460 children were removed from VPK. • 1,148 children in child welfare out of home care (2012-2013) • 54 suicides ages 13-24 (2011-2013) • 2,283 psychiatric hospitalizations. (2013).	• Grants • Technical assistance (national experts) • State data and some local data • Child collaboratives (Alliance, Cabinet) • Champions – Mayor Jacobs, Judge Perry • Federal dollars – two years left • Ability to implement filing fees • Wraparound Orange is a brand • Human Capital	• Implementation Team • Network Manager for the system • Credentialed Network of Providers with County wide complaint process • Centralized Intake/Single point of Access • In-depth Assessment - Child and Adolescent Needs and Strengths Assessment (CANS: • Care Coordination and Navigation services with Unified plans • Expand service array • Public Awareness Forum • Expanded Family Support/Advocacy • Accessibility • Management Information System to virtually link, all mental health/children serving organizations and the families served • Evidence Based Practice	• Forum for Community decision making and action • Accreditation/Accountability for providers • Monitoring of outcomes and adherence to the core values • 24/7 access by phone and website and behavioral health navigation • Community data and tracking Early Identification • Number of Targeted Case Managers trained • 24/7 mobile crisis teams, peer support, wraparound, Children's Community Action Teams • Kick-off (campaign community timeline) ongoing • Family Support Meetings across the community. • Partner with existing Neighborhood Centers across the County to serve families close to home • Systems Outcomes with accountability • Training for families and Service Providers	• Increase use of Civil Citation programs • Decrease child arrests for ages 5-10 • Reduce school suspensions/expulsions • Reduce number of children being removed from VPK • Reduce child welfare out of home placements • Reduce psychiatric hospitalizations and readmissions • Reduce suicide rates • Increase Family/youth resiliency • Increase Family/youth involvement • Reduce homelessness for transition age youth • Reduce/eliminate stigma • Reinvest cost savings into the overall system of care

Values - Family driven, youth guided, culturally and linguistically competent, strengths-based, comprehensive, coordinated, community-based, individualized, integrated, competent, respectful, outcome based, evidence based and focused on early prevention and intervention.

Orange County Children's Mental Health Commission Matrix

This draft matrix highlights various committees draft recommendations of the Orange County Children's Mental Health Commission.

The matrix is set-up into three sections: Local Short/Long Term, State Short Term, and State Long Term recommendations.
Each section identifies the recommendation, brief overview of the specification and the committee that recommended. Funding information is provided on the funding matrix. For complete details related to the recommendations refer to the individual committee reports.

Local: Short Term/Long Term

Network/System Recommendations	Brief Overview
Create Implementation Team - Management Network • Finance • Systems	• Orange County Government as the leader • Each committee chair shall recommend participants for the implementation of the System of Care • Established entity with representation from juvenile justice, child welfare, public school, managed care organizations, health and others deemed appropriate • Community Goal: Unite, Coordinate and Provide services amongst all systems so they work together. Blend and Braid funds as much as possible. • Update vision, mission and logic model. • Prioritizes/implements/obtains funding for all recommendations as well as further strategic planning (collective impact model) • Develops, evaluates and monitors key county indicators in child welfare, juvenile justice, etc. • Determines budgets • Acknowledged as a core function of county government and integrated into annual operating budget process • Needs dedicated support staff and budget • Responsible for administration, funding, credentialing, quality assurance and quality improvement, build partnerships. • Create a service delivery network. • Complete a service mapping of available services. • Develop and implement ongoing research and evaluation. • System complaint and feedback process. • Cross system trainings.
Expand System of Care Model (0-24yrs) • Finance • Systems	• Adopt the System of Care Model (Wraparound Orange) and core values (Family-Driven, Youth-Guided and Culturally and Linguistically Competent, evidence based). • Adopt the Family Support Model (empower families, provide resources and attain healthy and resilient children).

• Needs	• Obtain federal, state and local funding with the spirit of collaboration and transparency. • Focus on outcomes. • Coordinated Network, broad array of services. • Work with care coordinators/targeted case managers across community to adopt values. • Provide high-fidelity, evidenced based wraparound services in the County to those requiring a high-intensity service for avoiding out of home care. • Create an efficient and effective transition planning process to support children, youth and young adults. (From high school to college and college to community as an initial focus). • Implement Multi-systemic Therapy or Functional Family Therapy Models.
Create Information System • Systems	• Develop a Systematic Outcome-Driven Model • Consideration of previous evidence (where available) in system design or any redesign • Establish a core set of programmatic goals and objectives which are child and family specific • Establish a tracking and data collection system, ideally within a unified information technology framework • Begin process for a centralized point of entry with a management information system for referrals and community resources that includes coordinated care. • Uniform online referral • Resource information from system partners • Family access and tracking through services • Outcomes scorecard • Mobile communication devices
Develop Behavioral Health Navigation • Violence • Systems • Public Awareness	• Provides for a centralized intake, single point of access. • Create a community hotline • 24 hour access to qualified therapists who can counsel for bullying similar to national hotline in Canada, Kids Help Phone. • Access Portal needs new contact platform (voice/internet/texting) for youth-related, family mental illness issues, concerns. Example: (SpeakOut Hotline, managed by Crimeline). • Add a list of qualified providers by expertise, clients allowed, payment allowed and cost. • For Crisis management and referrals. • Front door for mobile crisis response. • Link with Behavioral Healthcare Navigators to get families linked with the right place quickly. Assigned from the hotline or take calls from community. • Make referrals to longer term services, such as wraparound, mentoring, counseling, CAT etc.

Children's Mobile Crisis • Violence • Systems • Public Awareness	• This "urgent" 24 hour response service provides crisis intervention and stabilization services to children and adolescents to include a 24 hour hotline
Reduce Impact of Violence on Children • Violence	• Encourage hospitals and OBGYN to screen all pregnant women utilizing HITS tool and Healthy Start Screening assessment for domestic abuse and refer to certified domestic abuse agencies. • Counseling for Children who are physically abused or witness Domestic Violence – 24 hour access to therapist • Identified children are referred to qualified providers for post incident counseling. • Establish a Credentialing Process for Counselors for child trauma • Creating an awareness and referral process for law enforcement, child welfare, school officials, etc. in which children who have witnessed a violence incident have the opportunity to seek appropriate counseling. • Bullying Counseling for Children who engage in bullying or are victims • Approach a local university about expanding its post graduate therapist training to include a specialization in child trauma treatment • Creation of an online listing of providers who met the minimum qualification • Fund research on the impact of social media, video gaming etc.... of violence in youth
Provide Community Training • Public Awareness • Systems	• Overview: Instructors are certified with goals of teaching **Mental Health First Aid** in local communities and support of program growth. Mental Health First Aid is a course designed to teach people how to: Help someone who is developing a mental health problem Help someone who is experiencing a mental health crisis • Learn how to identify; understand and respond to signs of mental illnesses and substance abuse disorders • Create/Implement **Crisis Intervention Team – Youth** Training for Law Enforcement • **Parent Training** – include topic of monitoring exposure to violence, video games, media etc...

Public Awareness Campaign Communication/Call To Action to Raise Awareness • Public Awareness	• Multi-level communication strategy and tactical plan shifting misperceptions, fears and behaviors associated with understanding mental illness to minimize stigma. • Public Opinion Survey to baseline • Develop Clear Messaging • Signature Event with Key Note like Pastor Rick Warren as kick-off • Road Show (billboards, PSA's, Blogs, etc.) • Develop Corporate Partners (Bright House, Walt Disney, Sea World, etc.) • School Presentations with parent/real family storytellers • Public Forum/Speak Out Platforms

	• Create glossary of key terms with appropriate language to describe mental illness • Dr. Oz expert on youth mental illness • Public Awareness at Orange County Public Schools Point of Entry – disseminated from top admin down • Identify what is currently available but perhaps not widely known. • Develop metrics: what works, what doesn't and what is appropriate audience receiving assistance. Include why?
Financial Strategies to establish Children' System of Care • Finance	• Look for opportunities to leverage community dollars and use them for need-driven services based • Conduct school system and community audits of existing services/programs (after-school, external programs, etc.) communication products and protocols • Explore viability for a fee assessed on related filings (ex: dissolution of marriages, red lights, forfeitures etc.) • Collaborate with managed care providers to improve care coordination and maximize resources across the systems. • Develop a policy to ensure any reallocated dollars from detention, inpatient psychiatric hospitalizations and child welfare are reinvested in appropriate system of care services for families. • Create incentives for monetary savings.

Expand Services for 0-5 population
• Systems
	• Establish a parent hotline with trained professionals to get questions answered, referrals made and support/education.
	• Create community educations programs that inform the public of the following (Long term—within 12-18 months)
	  o The importance of the pregnancy time period which impacts every developmental stage to life-long physical and emotional health and productivity.
	  o The importance of bonding and early literacy and stimulating your child in ways other than television and technology.
	  o The importance of choosing a quality caregiver for their children and continuity of care.
	• Create professional education programs the inform about:
	  o Ensure signs and symptoms of developmental delays and mental health issues are widely distributed to all those in direct contact with families to enable early identification/intervention. (Short term—within 6-12 months)
	  o Ensure all those dealing directly with families are trained on mandatory reporting of suspected child abuse. (short term—within 1 yr)
	  o The importance of involving fathers at all stages, when appropriate. When fathers are involved they are providing the necessary experiences to provide for solid brain architecture. (short term—within 6 months)

	• Training new parents
	  o Establish a program to educate and support families who experience a preterm or low birth weight delivery, while still in the hospital, since the risk of developmental delays and autism is increased. (short term—within 6-12 months)
	  o Ensure pregnant women and their partner and new parents are educated at each OB or pediatric visit on the value of breastfeeding, early feeding and nutrition to maximize brain development. (short term—within 6-12 months)
	• Providing parent support services
	  o Ensure services are available to pregnant and postnatal women for baby blues/depression, since about 20% will have that experience. (Long term—within 12-18 months)
	  o Offer parenting classes/support groups for parents at all stages of childhood that are widely accessible and affordable. (long term—within 2 yrs.)
	  o Implement a Nurse Family Partnership program in Orange County, an evidenced based program for at-risk families. (long-term—within 18 months to 2 yrs.)
	  o Implement the practice of all new families receiving at least one home visit post-natally within six months to offer reassurance, ensure all is proceeding normally and offer reassurance. (Long term—within 18 months-2 yrs./ongoing)
	  o Utilize family liaisons to follow up with parents entering any point of the system (Long term – within 18 months and ongoing)
	  o All programs offering assistance to families in our community, including but not limited to Healthy Start, Healthy Families, Early Head Start, 4C, Head Start, Early Steps, the Developmental Center, UCP, and the Early Learning Coalition's Baby Institute should be ensured adequate capacity to meet the needs in our community. (Long term/ongoing)
	  o Building on the success of the Orlando Magic Youth Fund (OMYF) Infant Toddler Child Development Associate (CDA initiative), increase the capacity of early learning training partners to deliver high quality CDA programs. These programs increase the knowledge of practitioners to recognize the early warning indicators associated with infant/toddler mental health.
	  o Provide incentives for early learning sites to fully implement a pre/post assessment that incorporates infant/toddler mental health indicators.
	  o Increase the capacity of early assessment and intervention through increased staff for the Early Learning Coalition of Orange County (ELCOC), Early Steps and OCPS Early Intervention.
	  o Building off of the Michigan Child Care Expulsion Prevention Program (findings presented in the Gulliam report), provide access to mental health/behavioral consultants/specialists to work with early learning sites (both centers and homes) to support intervention plans.

	• Develop trauma protocols for the 0-5 population based on an increase in referrals for children ages 1-3 (per KinderKonsulting).
Expand Services for 18-24 population • Systems	• Expand Family Therapy specialty training with a focus on working with families with teens; • Improve Individual therapy models with a focus on working with teens and young adults; • Provide easier access to psychiatric care (especially outpatient care) ensuring that young adults without coverage can receive needed services. • Provide specialized training for service providers in working with this age group; • Provide Domestic Violence training that is specific to this age group; • Promote/require youth involvement in deciding the best setting for and type of services to address challenges. • Provide case management and wraparound services to youth/young adults in transition stages (high school to college, college to community, etc.) • Recommendations for UCF students involved with UCF Cares o Better coordination/communication of services between departments (adopt no wrong door philosophy) o Use of a Management Information System to manage/coordinate student data o Utilize case management on campus via CAPS program o Abolish "session" limits of 12 sessions per year (offset costs by using by billing insurance) o Offer crisis services and use peer support via a student run volunteer program o Provide 24/7 online and hotline suicide services with peer support using IMAlive or creating a volunteer student network.

State: Short Term

Recommendation	Brief Overview
Children's Action Treatment Team (CAT-Team) • Finance • Systems	Provides intensive services for youth with a severe and persistent mental health disorder.
Consider a change in state statute to address Bullying • Violence	• Current state law requires victims to meet the standard of stalking. • Compare Florida bullying law to other states to determine if a change in law is necessary to allow for greater accountability *Legislation (HB 451) has been introduced this session to criminalize bullying*

State: Long Term

Recommendation	Brief Overview
Diversify the service array provided by insurance companies across the community • Finance • Systems	• Expand coverage of/or create new types of children's services (wraparound, peer support, respite, etc.) available through a strategic marketing/outreach plan to Managed Care Organizations both Medicaid and Private. • Educate State Leaders and Legislatures

ORANGE COUNTY MAYOR
TERESA JACOBS

P.O. Box 1393,201 SOUTH ROSALIND AVENUE,ORLANDO, FL 32802-1393
PHONE: 407-836-7370 • FAX: 407-836-7360 • Mayor@odl.net

August 5, 2013

Mr. Bill D'Aiuto
Regional Managing Director
Department of Children and Families
400 W. Robinson Street, Ste S1129
Orlando, FL 32801

Dear Mr. D'Aiuto,

From Columbine High School to Virginia Tech to Sandy Hook Elementary, our nation has been shocked by the recurring loss of innocent lives lost at the hands of disturbed young people. As demonstrated by the near-tragic incident that occurred earlier this year at the University of Central Florida, Orange County is not immune from such violence, so much of which is rooted in mental illness. In the wake of these and other heartbreaking instances of youth-perpetrated violence, and as part of a much larger responsibility to provide for the health and well-being of our community, we have a responsibility to address the mental health-related root causes of these tragic incidents.

Incredibly, more than 50 percent of all lifetime mental health issues are present before age 14, and *75 percent before age 25.* As the statistics note, the sooner we screen, detect and treat, the better for all, including the extended families of affected young people. Dealing with an issue of such complexity will be no small challenge, and will require the commitment of our entire community and all levels of government. From my point of view, it makes the best sense to focus on this task in a holistic, integrated manner. As an immediate next step, I will be convening a commission of community leaders to assess our current resources, to hear expert testimony about our current state of affairs – including gaps or duplications, as well as first-hand testimony from young people who have dealt with these challenges – and to present inclusive recommendations to our Orange County Board of County Commissioners.

May I ask you to accept appointment to the Orange County Youth Mental Health Commission?

I would like this to be a very short and focused Commission, bringing recommendations to our Board by early in 2014. While the Commission will likely meet only three to four

times, individual Commission members may be appointed to specific sub-committees with more aggressive schedules. Our first meeting will be held on, Monday, August 26th, from 8:30am to 11:00am in the Orange County Board of County Commission Chambers located in the Orange County Administration Building at 201 S. Rosalind Avenue, Orlando, FL 32801. Please RSVP your attendance and interest to Reggie Paros at Reggie.paros@ocfl.net or 407-836-7370. For more information about the work of the Commission or current resources, please contact Donna Wyche, our Orange County Family Services Division Manager, at Donna.Wyche@ocfl.net or 407-836-7608.

Thank you for the work you are doing to help make Orange County the best place to live, work and raise a family. I look forward to the challenges of this assignment and thank you, in advance, for your interest in our community and citizens.

Sincerely,

Teresa Jacobs

c: Chief Judge Belvin Perry, Commission Co-Chair
Rich Morrison, Florida Hospital, Commission Co-Chair

Orange County Youth Mental Health Commission
Purpose Statement

Purpose Statement
To develop effective strategies and initiatives to improve: 1) the Mental Health of Children, Adolescents and Young Adults in Orange County and 2) the system of Mental Health education, prevention and care for youth in Orange County.

General Approach
The Commission will examine the extent of youth mental health issues in Orange County and determine the effectiveness of approaches and programs in other communities in:

- Preventing problems
- Early identification
- Treating mental health issues
- Availability of resources and programs
- Changes and/or additions to county systems to make resources more effective.

An important focus will be developing strategies to eliminate the stigma associated with Mental Illness as well as financial sustainability.

The majority of the work will be done via committees and ad hoc workgroups. These committees will consist of Commission members and individuals with expertise in the mental health field as selected by the various commission chairs. The Commission's responsibility will be to evaluate proposed committee recommendations and develop a comprehensive plan that fulfills the purpose statement. The work of the Commission will inform public policy, resource allocation, strategies and priorities for Orange County in the area of Mental and Behavioral Health for the Youth of our community.

Mayor's Youth Mental Health Commission
Needs Assessment Committee

Final Report

Chair:
Glen Casel, Community Based Care of Central Florida
Maria Bledsoe, Central Florida Cares Health System

Committee:
Angie Hilken, KinderKonsulting & Parents Too
Carlos Pozzi, Devereux Florida
Courtney Fry, Community Advocate
Gayna Hansen, Value Options
Jessica Sams, Community Based Care of Central Florida
Judeen Parks, Jamaican-American Association
Dr. Karen Hofmann, University of Central Florida
Karen Willis, Early Learning Coalition of Orange County
Ken Henderson, University Behavioral Center
Dr. Lauren Josephs, Visionary Vanguard
Lisa Kroger, Devereux Florida
Dr. Michael Campbell, Nemours Children's Hospital
Seyny Dressler, Youth Advocate Program
Dr. Stephan Brown, Visionary Vanguard
Steve Dalsemer, Human Services Associates
Tammy Speed-Hefner, Orange County Public Schools
Teresa Burt, Community Based Care of Central Florida
Therese Murphy, Marketing Consultant
Uschi Schueller, KinderKonsulting & Parents Too
Vicki Garner, Lakeside Behavioral Healthcare

Staff:
Donna Wyche, Orange County Mental Health & Homeless Issues Division
Anne Marie Sheffield, Orange County Mental Health & Homeless Issues Division
Heather Thomas, Orange County Mental Health & Homeless Issues Division

Orange County Youth Mental Health Commission
Needs Assessment Committee Final Report

Objectives:

1. To identify the current and future needs for mental health services, the state of current prevention and early identification programs and the areas where meaningful information is lacking.

2. To identify the difference between organic issues of mental health and behavioral issues and the extent of those issues in Orange County.

3. To identify by relevant social demographic factors the incidence of various mental health issues.

4. To establish meaningful and measureable metrics to assess progress in both treatment and prevention.

Overview

The Needs Assessment Committee approached the task of completing the objectives through discussion, review of state and national reports, review of local, state and national data, (based on what was available and accessible). Additionally, the Needs Assessment Committee participated in joint meetings with the Systems Design Committee and "All Committee" meetings. The Needs Assessment Committee has provided information from a "systems-level" view and determined that it was not feasible or appropriate to attempt to gather information on individual gaps in services: waiting lists, types of services available and accessible. It should be noted that data sets were difficult to obtain in Orange County as all the large systems collect and report data differently creating an inability to compare data sets against each other. The Needs Assessment Committee was able to obtain some local data that is mapped out in the report and has provided recommendations for the data points that are reflective of the mental health and well-being of children, youth and young adults in our community. Additionally individual indicators are identified. The result of the work of the Committee is that Orange County's current Youth Mental Health System for children/youth/young adults ages 0-24 is fragmented, uncoordinated and woefully underfunded in comparison to national standards.

Orange County Data

Population: Based on 2011 census data, Orange County has a population of 1,157,342 of which 273,753 are children under the age of 18. The number of children in Orange County is projected to rise to 369,414 by the year 2030, and the percent of children will remain relatively stable at 23.1% of the total population, (Kids County Data Center, 2011).

Funding: Florida is currently ranked 49th in the nation in funding for mental health services. Orange County and the central Florida region is the 2nd lowest funded in the state, despite having the fourth largest child population in Florida, (Kaiser Foundation, 2013). Additionally, 2011 data indicates there were 210,885 persons living in poverty in Orange County and 69,633 were under the age of 18. According to the 2013 PRC Child and Adolescent Community Health Needs Assessment sponsored by Nemours Children's Hospital, 6.2% of families report having no coverage for their child's healthcare expenses.

Projection of Need: National data indicates that 20% of the population has a mental health/substance use disorder. In the age group of 0-24, this equates to 83,791 children and young adults with a disorder and in need of services.

Prevalence Data of types of Mental Health Disorders: It is estimated that 15 million of our nation's young people can currently be diagnosed with a mental health disorder that is causing significant stress and impairment at school and home (Department of Health and Human Services 2008). This means that about 20% of children (1 in 5) ages 8-15 have a diagnosable mental or addictive disorder (U.S. Department of Health and Human Services, 2008).
Based on data derived from the 2013 PRC Child and Adolescent Community Health Needs Assessment, Behavioral Health concerns for Orange County (OC) youth mirror the national (USA) trend on many key measures.

- Autism (OC 3.4%; USA 3.7%),
- ADD/ADHD (OC 12.4%; USA 12.1%),
- Anxiety (OC 8.1%; 8.2%)
- Depression (OC 5.2%; USA 5.4%).

Beyond the diagnostic data, there are some key findings of concern for youth mental health in Orange County. Specifically, children ages 5-17 had a higher rate of 2+ weeks of feeling sad / hopeless in the past year (OC 8.7%; USA 6.0%). This combined with the higher prevalence of attempted suicide among high school students (OC 8.1%; USA 7.8%) and the significantly higher level of parental lack of knowledge about community mental health resources available (OC 50.3%; USA 68.8%) paints a bleak picture for the current state of the Orange County mental health system.

Organic vs. Behavioral – Through research and discussion the Needs Assessment Committee recognizes this is a complicated issue based on biology, environment, trauma and other stressors. There is not enough advancement in the field of psychiatry to ensure that the two can be separated. Additionally, behavioral problems may be an indicator for a long-term mental health

disorder. Because of these issues the types of behavioral symptomology that is present in a child/youth/young adult impacts the type of treatment to be provided and has no impact on whether to provide treatment or not. Every child/youth/young adult is entitled to a holistic treatment approach that requires understanding them in the context of their environment and in the context of their experiences.

Demographics: A snapshot of children and youth who received behavioral health services in Calendar Year 2010, indicates that for children who received behavioral health services only, they were most likely to be

- Male (60.3%)
- Black or African – American (30.8%) or of other racial / ethnic descent (30.2%)
- Ages 7 – 12 (48.8%).

The most common behavioral health services these children and youth received were Outpatient Mental Health services (67.3%), Mental Health Screening or Assessment (65.1%), and Medical Evaluation and Management (33.1%).

County-Wide Key Indicators (Scope of the Need)

Juvenile Justice Data

	2010-2011	2011-2012	2012-2013
State of Florida Arrests	108,407	95,175	83,494
Orange County Arrests	9,815 (9%)	8,405 (8.8%)	7,520 (9%)
Orange County Felony Arrests (increase 6%)	2,332 (24%)	2,243 (27%)	2,250 (30%)
Probation (increae 16%)	1,730	1,599	1,849
Diversion (decrease 16%)	2,577	1,964	1,651
Commitment	279	257	188
Transfer to Adult	224	263	184

*** ***Information obtained from the Florida Department of Juvenile Justice Dashboard***

Arrests by Age

Orange County	2010-2011	2011-2012	2012-2013
5-10 yrs	149	113	84
11-12 yrs	459	367	404
13-14 yrs	1,830	1,683	1,553
15 yrs	1,843	1,568	1,508
16 yrs	2,375	2,046	1,780
17+ yrs	3,159	2,628	2,191

Civil Citation

	2011-2012	2012-2013
State of Florida	6,933	7,329
Orange County	8	93

Department of Juvenile Justice PACT (Positive Achievement Change Tool Assessment)
The PACT Assessment is a comprehensive assessment that addresses both criminogenic needs and protective factors, from the moment a youth enters the system to the moment they exit. (Note the outcomes below are not reflective of the complete assessment)

Orange County Juveniles	2007	2012
High risk	21%	25%
Has used drugs	60%	63%
Has used alcohol	40%	44%
Anger problem	20%	35%
Victim of Trauma/Neglect	62%	75%
Witnessed Violence	60%	73%
Antisocial Peers	84%	90%
Parent with MH/SA	14%	19%

An overview of the full PACT assessment from 2007 - 2012 indicated the following for juveniles in Orange County. Comparatively, these outcomes are very similar to the Statewide outcomes:

- 44% indicate a Mental Health Issue
- 26% indicate a Mental Health Diagnosis
- 4% report Suicide Attempts
- 27% report diagnosis of ADHD

**** note that National Data indicates 60-75% of juvenile justice youth in a juvenile commitment program have a diagnosable mental health disorder*

Orange County Public Schools
The Orange County public school system is the 10th largest in the nation and is the 4th largest in Florida. Orange County Public Schools has an 86% graduation rate (OCPS, 2012).

Number of Schools	Number of Students
Elementary**	123	82,277
K-8	3	2,832
Middle	35	38,640
High	19	50,902
Exceptional	4	609
Alternative		2,340
Charter		9,593
Total 184		**187,193***

***Includes Pre-K *As of Oct. 15, 2013*

Orange County Public School Disciplinary Action

OCPS	2011-2012	2012-2013
Suspensions	27,446	28,517
Students Suspended	16,248	15,273
ESE Students Suspended	3,872	3,506
Expulsions	20	27

Orange County Public Schools Student Racial/Ethnic Distribution

White.....62%
Black.....29%
Asian.....5%
Multi-Cultural.....3%
American Indian/
Alaska Native.....1%
Hispanic.....36%
Non-Hispanic.....64%

Orange County Public Schools Students Suspended Compared to Student Enrollment (students without disabilities – CRDC, March 2012)

	White	African American	Hispanic	Asian/Pacific Islander	American Indian	
Suspensions	16%	54%	29%	1%	.2%	
Enrollment	34%	28%	33%	5%	.5%	

According to the Civil Rights Data Collection (CRDC) African American boys and girls have higher suspension rates than their peers. One in five African American boys and more than one in ten African American girls received out of school suspension. Additionally, students with disabilities are twice as likely to receive one or more out of school suspensions. In a recent CRDC study, 1 out of 8 students had a disability, 4.7 million served by IDEA and over 400,000 are served by Section 504 only. Nearly 18% of them were African American Males (CRDC, 2012)

Orange County Public Schools 9th-12th Grade, Single-Year Dropouts by Gender within Race/Ethnicity, 2008-2009 through 2010-11

	White			Black or African			Hispanic/Latino			Asian		
2008-09	1.4%	1.8%	1.6%	3.0%	3.7%	3.4%	2.2%	2.9%	2.5%	0.6%	1.0%	0.8%
2009-10	1.2%	1.6%	1.4%	2.6%	3.5%	2.9%	2.1%	3.0%	2.5%	0.7%	0.8%	0.8%
2010-11	1.1%	1.6%	1.4%	2.5%	3.4%	3.0%	1.7%	2.5%	2.1%	0.5%	0.8%	0.6%

Orange County Public Schools overall dropout rates continue to improve to just under 2% in the 2010-2011 school year. Each student who drops out of high school costs our society $260,000 (Riley& Peterson, 2008) in lost earnings, taxes, and productivity (much more when you factor in

the extra financial and social costs of delinquency, prison, teenage parenting, and publicly funded entitlements such as Medicaid, food stamps, and Temporary Assistance for Needy Families) .

Early Identification – Orange County Public Schools

Several epidemiological studies of children's mental health needs and services have led to the conclusion that in this country schools are the de facto mental health system for children. This conclusion is based on the finding that for children who do receive any type of mental health service, over 70% receive the service from their school (Duchnowski, 2006).

Pre Kindergarten Students	2011-2012	2012-2013
Students Screened	1,348	1,388
Referred to outside services	50	40

From July 2013 to June 2014 a total of 629 referrals were received by the Early Learning Coalition of Orange County (ELCOC) from early learning providers. 192 (30%) of those were for behavioral concerns. Twelve percent (12%) of Orange County Head Start children were referred for behavioral assessment during Fall, 2013. And during a 4 month period (August to November 2013) over 460 children (4.2%) enrolled in the State funded pre-K program (VPK) were either asked to leave the by their provider or removed from VPK by their parent. While the reasons for the removal vary, self-reported coding indicates behavior, safety of other children, and failure to meet expectations were often cited.

Special education costs $10,000 per student per year above the cost of regular education (Parrish et al., 2004).

OCPS 2013 -2014 budget for salary (includes benefits)

- 9 licensed mental health counselors - $533,041
- 91 school psychologists - $8,211,472
- 50 social workers - $3,410,952

Child Welfare - Prenatal

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.

According to the 2013 PRC Child and Adolescent Community Health Needs Assessment between 2009 and 2011, 23% of Orange County pregnant mothers did not receive prenatal treatment in the first trimester. This number rose to 39.9% amongst teen pregnancies. Children birth to age five who have social and emotional problems early in life are more likely to experience later problems as well as to develop serious mental illnesses later in life.

Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty. Reports indicate that 3-19% of pregnant women are battered.

Domestic Violence

- Between 3% and 9% of pregnant women are battered (Sharos, Laughon, Giangrande, 2007).
- In 2011, Orange County had 8,086 reports of intimate partner violence (FCADV, 2012).
- Trauma, abuse and neglect have a lasting, permanent effect on the brain, affecting learning, good social and emotional health and risk for child aggression and violence (Perry, 1997).

Child Welfare Data

State wide/ Orange County	2011-2012	2012-2013
Child Protection Investigations	187,997/unable to obtain	182,288/unable to obtain
Out of Home	20,099/1,339	20,771/1,148
Reunification within 12 months	68%/unable to obtain	64%/34%
Abuse Hotline Calls	449,677/unable to obtain	462,720/unable to obtain

*** ***Obtained from the Department of Children and Families Dashboard***

The median length of stay in foster care or other out-of-home placements for youth in care was 11.9 months (Armstrong, Sowell & Yampolskaya, 2012). In 2011, Foster care costs $32,000 per child annually (Hillsborough Kids, 2011).

CBC of Central Florida Child Welfare Data, 2012-2013

- 1,148 children in child welfare are residing in out-of-home care. Downward trend from 1,339 last year.
- Performance measures for diversion are on target.

- Problem areas are children receiving permanency within 12 months of entering care (34.1%) and children receiving permanency after 12 months in care (40.4%). The entire state struggles with the same.
- Orange County is below other areas in the state for youth ages 19-22 with a diploma or GED at 46.9%.

*** *from the Department of Children and Families report card scores.*

Suicide Data

According to the District Nine Medical Examiner's Office, from Feb, 2011, to Feb, 2014, there have been 58 teen/young adult suicides (ages 14-24). (5 listed by drug death, 21 by gunshot wound, 22 by hanging, and 10 by other methods).

Based on data derived from the 2013 PRC Child and Adolescent Community Health Needs Assessment children age 5-17 had a higher rate of 2+ weeks of feeling sad/hopeless in the past year (Orange County 8.7%; USA 6.0%). There was also a higher prevalence of attempted suicide among high school students (Orange County 8.1%; USA 7.8%).

Substance Abuse Data

Results of the 2012 Florida Youth Substance Abuse Survey - Orange County Report showed that 36.1% of sampled middle school students reported alcohol or other illicit drug use in their lifetime with 15.9% using during the past 30 days.

Behavioral Health Data
Orange County Baker Acts by Provider

	2010	2011	2012	2013
SAMH Funded	Unable to obtain	Unable to obtain	341 (duplicated in other numbers)	182 (duplicated in other numbers)
University Behavioral Center (includes some Seminole County)	75	155	139	405
Lakeside Behavioral Healthcare (75% Managed Medicaid)	1147	1235	1121	1277
Central Florida Behavioral	Not Provided	Not Provided	Not Provided	601
Total	1,222	1,390	1,260	2,283

2013 PRC Child and Adolescent Community Health Needs Assessment reports 7.1% of Orange County parents believe that their (age 5-17) child's mental health is "fair" or "poor." Parents reported that they were told by their child's healthcare provider that 7.8% had anxiety and 4.8% had depression. Additionally, 8.7% of parents indicated their children (ages 5-17) felt sad or hopeless two or more weeks in the past year. Orange County responded unfavorably high compared to surrounding counties and national responses. Other areas of concern where Orange County responded higher include reports from families that their child worries a lot, has difficulty falling asleep, has made suicide attempts, and is on prescribed medication.

- 8.1% reported attempting suicide
- 11.4% ever taken prescribed mental health medication

Focus group members perceive poor mental health to be a serious health concern for children and adolescents in their community. Participants agree that mental health status correlates with a child's physical health, and that healthcare providers need to care for the whole person. With that said, the study indicated that just 50% of parents were aware of what mental health resources were available in Orange County, far below national and local findings.

System Design Analysis

The Needs Assessment Committee has identified six major areas of need to be addressed in any system redesign project. The factors overlap and interplay and together create a cycle of ineffectiveness. As a child and family move around the system the issues and challenges worsen.

The six major factors of needs identified are: **lack of system design or coordination, financing model disincentives and poor accountability, restrictive service array (wrong mix of services), system complexity, inadequate resources (prevention and intervention), and lack of system accountability**.

1. **Lack of a system design and coordination**

In Orange County, our needs begin with the lack of a coordinated, well laid out, overall system design. Major systems, juvenile justice, child welfare, public education, health and prevention each operate independent of one another with their own set of rules and standards, the result being a system that is fragmented, ineffective and inefficient in the use of federal, state, and local resources.

Children's mental health services are disconnected from other child serving systems. The systems do not meet on a regular basis and do not develop cohesive plans that address the needs of the community. Our community designs programs based on available funding. Programs may or may not impact the overall health and wellness of children and families. These

communication breakdowns prevent children from being effectively identified, easily and effectively referred, and properly treated. The lack of overall system design discourages the critical role of collaboration with all child serving systems.

Results:

- Only 27% of children's mental health needs are met in Florida
- Only 34% of adult's mental health needs are met in Florida
- Only 15% of anyone's substance abuse needs are met in Florida ******Obtained from the Department of Children and Families strategic plan, 2014-2016.*

The lack of system design impacts families in that they have a basic uncertainty of how to get help. A retrospective study completed by Wraparound Orange showcases comments from parents: "Where do I go"? "How do I find services"? "Why do I have to play middle man for my treatment providers"? "Why do I have to tell my story over and over to each provider"? "I don't understand how to negotiate the system"! "I'm exhausted trying to help my child"! These are just a few of the questions and comments we hear from parents. It is easy to demand "work better together", but we must recognize the role that system design plays in effective collaboration.

Results: According to (Professional Research Consultants Report) only 50.3% of parents are aware of mental health resources in the community. That is 18.5% lower than the United States Average.

Lack of consistent training

Training across the community is inconsistent. Trainings are duplicated by multiple systems. There is a lack of use of fidelity measures and coaching models to ensure that the trainings provided result in use of an evidence-based practice. There is no formal credentialing of providers or any accountability for provider outcomes in our community.

Not child centered

The lack of a coordinated system leads provider-based service delivery, and not child centered services. Youth and their families are shuffled from one service to another or from one location to another, searching for funding and/or eligibility, rather than focusing on the child's immediate mental health needs, this leads to poor outcomes and higher costs. Families are rarely engaged in services, leading to treatment drop outs and missed opportunities (Burns, 2012).

Results:

- Services are delayed or not received at all.
- Increased frustration.
- Leads to child decompensation, re-offending, and/or child welfare involvement.
- Florida ranks 44th in the nation in health care system performance (i.e., access, treatment, avoidable hospitalizations) (Kaiser Foundation, 2010).
- Florida ranks 3rd in the nation in number of juvenile detention facilities (Kaiser Foundation, 2010).
- Florida ranks 4th in the nation in number of children in foster care (Kaiser Foundation, 2010).

2. **Inadequate funding, financing model disincentives and poor accountability**
The system of care for children in both Orange County and the State of Florida are reflective of the payer sources and funding model that has existed for many years. Currently, children's services in Orange County, Florida, are funded by a combination of private, state and federal sources. This variety of funders has an equal number of requirements for accessing the services funded. For that reason multiple providers of children's behavioral health services exist in the area. Many of the available services are paid for by Medicaid or the State of Florida Department of Children and Families who contract with the Managing Entity in this region (Central Florida Cares Health Systems). Other forms of funding consist of federal grants for specialized programs and private insurance for the child whose family is covered by insurance plans provided by employers. Child welfare services are provided by a combination of funding from the State of Florida to Community Based Care and Medicaid, which in Orange County will be entirely privatized by August, 2014.

Services provided to children court-ordered into juvenile justice programs are provided by contractors via the Department of Juvenile Justice. The problem with this is that often the persons providing the services have a dual role. Ensuring court compliance AND engaging them in a treatment process. This creates a conflict in the therapeutic process. This method of funding is driven by the payer and has little or nothing to do with the needs of the child or family. Multiple funding streams that work independently of one another have created a system with large gaps. This shifts the burden to the family to find appropriate services.

- 30.5% of Orange County parents report some type of difficulty or delay in obtaining healthcare services for their child in the past year (PRC, 2013).

To complicate the complex manner in which services are funded, funding in Florida has focused on deep-end or crisis treatment rather than prevention of behavioral health and substance use disorders.

- Florida is 49th in the United States in the level of funding for behavioral health services at a mere $38.17 per capita. (Politifact).
- Florida ranks 49th in the nation in funding for mental health services, this is $39 per person per year (Kaiser Foundation, 2013).
- Mental Health funding is less than it was in the 1950's (Florida Council for Community Mental Health, 2013).
- Community mental health system funding has remained flat with only a 3% increase in the last 5 years. During the same time period, adult mental health funding has declined 7.9% (Florida Council for Community Mental Health, 2013).

The lack of system design can be traced directly to the financial workings of our mental health delivery system. Funding comes with complex and competing requirements, often creating disincentives to accomplish results. Accountability is frequently misguided, placing too much emphasis on certain requirements, while largely ignoring other critical areas. This financial design must change to achieve an effective mental health delivery system.
Results:

- Fragmented funding leads to an uncoordinated system with overlapping and gapped services.
- Separate funding sources provide competing or conflicting requirements.
- Financial incentives promote perpetuating the problem, not solving.

3. **Restrictive service array: families receive the wrong mix of services**

The lack of system design and disconnected financial model leads directly to a mental health service mix inconsistent with the needs in the community. As needs shift, the system is slow to react and results in services that do not match needs. Families receive what a provider "has to offer" verses what they actually need. The services are driven by what is allowed or funded and not necessarily by the presenting need identified. A parallel to health care would be for a Doctor to offer surgery for the flu, because that is "what I can do".

Silo's/units - Mental health services in Orange County are delivered, almost completely, in "units", one distinct service at a time. Often these individual services sit separately from any other services the child may be receiving. This delivery reality creates service "silos" that are uncoordinated and misinformed to meet the mental health needs of children.

Requirements - Each service provided comes with a unique set of requirements. Parents are frequently sent from one service provider to another as a result of these distinct qualifying requirements.

Improper Assessment -Each provider performs an assessment which is extremely time consuming and duplicative in nature. Systems do not communicate with each other or share information despite the technological availability for sharing of electronic medical records. This is inefficient and frustrating for families.

Not child centered - The current system forces families to "chase" services that are inappropriate or unavailable to meet their unique needs. Families are given a list of referrals and expected to determine eligibility and availability with each referral. There are multiple portals for obtaining services for families resulting in confusion and inability to find the appropriate service. Families are forced to accept the services that agencies offer which are not necessarily the services they need.

4. **System Complexity**

There are multiple services available in Orange County and children/youth and families may participate in overlapping services with no coordination or communication among providers. Parents are often left to "figure it out" and most professionals are unable to navigate service delivery.

Child and family needs are complex

- Youth with serious behavioral health challenges typically have multiple and overlapping problem areas that need attention.
- Families often have unmet basic needs.
- Traditional services don't attend to health, mental health, substance abuse, and basic needs holistically which leaves many families frustrated and not sure where to begin.

One parent shared with us that "if you are one of the lucky families to actually make it this far in the process with good providers and communication, the complexity might cause you to throw up your hands and give up. Services occur in "silos" meaning they neither coordinate nor communicate with each other. Systems don't work together well for individual families unless there is a way to bring them together (Bruns, E. 2012).

Results:

- Youth get passed from one system to another as problems get worse.
- Families relinquish custody to get help.
- Children are placed out of home.

Lack of access -With the lack of a clear entry point or clear eligibility, access becomes a challenge. Simple information and referral is ineffective, as families may end up with a list of providers for which they do not qualify. Providers are equally frustrated, wasting precious resources on qualification verifications and duplication of verifications.

According to the 2013 PRC Child and Adolescent Community Health Needs Assessment many focus group participants are concerned with access to healthcare services for children and adolescents and identified the following barriers:

- Health literacy
- Poverty
- Insurance status
    - Uninsured
    - Medicaid
- Prescription drug costs
- Cultural competence
- Transportation

Transportation challenges - Service availability varies greatly across the County, and there may be a service available to a child, that families cannot access due to either location of services and/or hours of operation of provider. The difference between access to services from Bithlo to Pine Hills to Downtown have very different challenges. The current system does not effectively account for these variations. Some of our parents work; some are without reliable transportation or ability to drive. Additionally, the current transportation system puts Orange County at an economic disadvantage in comparison to other major cities.

5. **Inadequate Resources (prevention/intervention)**

Services not available –Evidence-based practices for prevention of development of severe behavioral health problems exist and are demonstrated to be highly effective. Very few funding sources exist in Orange County that will cover these services. Proactive, preventative services are the best chance for a child identified as being at risk at an early age. These services are a child's best chance for transition into a successful adulthood. Without proper prevention services children remain at risk for ending up in deep-end services. Negative impacts to the community may be higher rates of violence and incarceration, exacerbation of severe mental illness and substance dependence and increased homelessness.

Results:

- In 2012-2013 Orange County Public Schools reported over 7,000 students were homeless. This is a 300% increase in the last 6 years. 79% of the homeless students indicated that they reside with friends or other family.

Wait times/lists - Whether a family is trying to access public funded care or insured care, often there is a waitlist for services and a minimal amount of visits permitted through insured care. At the time of this report, the publicly funded provider in Orange County had a 5 week waitlist for uninsured youth. Many insurance companies limit the number of psychiatric visits and services. Like most medical issues, wellness/stability is not achieved in 6 visits. Additionally, families who have private insurance and have not exhausted their benefits must turn to the public sector. Pires, 2012).

Despite effective treatments, there are long delays, sometimes decades, between the first onset of symptoms and when people seek and receive treatment. An untreated mental health disorder can become more severe, more difficult to treat, and/or increased comorbidity.

Results:

- Only 20%-50% of these children receive mental health treatment.
- Half of all lifetime cases of mental health disorders begin by age 14.

6. **Lack of System Accountability**

Lack of Data, Technology - A key component to any thorough needs assessment is the ability to effectively and efficiently evaluate the outcomes of the services offered (Taylor et al., 2002). A well-functioning system has an element of program evaluation built into the process at the onset. Key components of the program evaluation process include the systematic collection of data elements that mark the onset of care through the termination of care across the system (Rubin & Babbie, 2013).

Each child-serving system of care has a database and most utilize electronic records. Across the community in general there have not been any attempts to share information across systems to improve care offered to youth and families. Measureable outcomes are vital to improving systems and every agency and system has to agree to achieve transparency in data and outcome sharing.

Conclusions/Recommendations

The Needs Assessment Committee concludes that the current Youth Mental Health System for children/youth ages 0-24 is fragmented, uncoordinated, and woefully underfunded in comparison to national standards. Orange County data from all child-serving systems clearly support that our system is ineffective and does not meet the needs of children and families in our community. The body of research from around the nation is sufficient to provide Orange County with the information on the standards needed to create cost effective and lasting change in our County and allow us to attain better outcomes for children, youth and families. Therefore, the Needs Assessment Committee fully supports the recommendations from all of the other Committees under the Youth Mental Health Commission and in addition recommends the following:

1. Begin with setting the structure for outcomes to be attained through a Management Network.
2. Ensure alignment with other initiatives (Children's Summit, Alliance Board, etc.).
3. Establish a system for collecting data at the individual, family and community level.
4. Create a community dashboard to monitor each area of the outcomes desired with the following as a starting point.
    - Increase use of Civil Citation Programs.
    - Decrease child arrests for ages 5-10.
    - Reduce school suspensions/expulsions.
    - Reduce number of children being removed from VPK.
    - Reduce child welfare out of home placements.
    - Reduce psychiatric hospitalizations and readmissions.
    - Reduced the incidents of suicide in the 0-24 population.
    - Increase Family/Youth resiliency.
    - Increase Family/Youth involvement.
    - Reduce homelessness for transition age youth.
    - Reinvest cost savings into the overall system of care.

REFERENCES

Armstrong, M.I., Sowell, C., & Yampolskaya, S. (2012). *Florida's IV-E Waiver Demonstration Project: Evaluation Summary Brief.* Department of Child &Family Studies Louis de la Parte Florida Mental Health Institute USF College of Behavioral & Community Sciences. Retrieved from www.cbcs.usf.edu.

Bruns, E. 2012. University of Washington.

Civil Rights Data Collection (CRCDC). *The Transformed Civil Rights Data Collection, March 2012.* Retrieved from www.ed.gov/ocr.

Florida Coalition Against Domestic Violence (FCDAV). (2013). Retrieved from www.FCDAV.org.

Florida Council for Community Mental Health. (2013). *Florida's Behavioral Health Crisis.*

Florida Department of Children and Families, *Strategic Plan.*

Kaiser Family Foundation. (2012). Retrieved from www. Kff.org.

Kutash, K., Duchnowski, A. J., & Lynn, N. (2006). S*chool-based mental health: An empirical guide for decision-makers*. Tampa, FL: Research & Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of Florida.

Hillsborough Kids, Inc. (2011). Tampa, Fl.
Orange County Public Schools. (2013). *2013-2014 Pocket Budget Guide.* Retrieved from www.ocps.net.

Parrish, T., Harr, J., Wolman, J., Anthony, J., Merickle, A., & Esra, P. (2004). State special education finance systems, part II: Special education revenues and expenditures. Palo Alto, CA: Center for Special Education Finance, American Institute for Research.

Pires, S. 2012. Washington DC: Human Service Collaborative.

Pires, SA, Grimes, KE, Allen, KD, Gilmer, T, Mahadevan, RM. (2013), (in press) *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures.* Center for Health Care Strategies: Hamilton, NJ.

Professional Research Consultants, Inc. (PRC). (2013) *Child & Adolescent Community Health Needs Assessment*, Nemour's Hospital Orlando.

Riley, R.W., & Peterson, T.K. (2008). Before the 'either or' era: Receiving bipartisanship to improve America's Schools. Education Week.

Rubin, A. & Babbie, E. (2013). Essential Research Methods for Social Work. Belmont, CA.

Sharps, P. W., Laughon, K., & Giangrande, S.K. (2007). *Intimate Partner Violence and the Childbearing Year: Maternal and Infant Health Consequences.* Trauma, violence, and abuse: Vol 8, No. 2. Retrieved from www. Sagepub.com.

Substance Abuse and Mental Health Administration (SAMHSA), 2013. SAMHSA.gov.

Taylor-Powell, E. Jones, L., & Henert, E. (2002). Enhancing program performance with logic models. University of Wisconsin.

U.S. Department of Health and Human Services. (2009).*Child welfare outcomes 2006-2009: Report to Congress: Safety, permanency, well-being.* Washington, DC: U.S. Department of Health and Human Services Children's Bureau.