Mayor's Youth Mental Health Commission
Systems Design Committee

Final Report

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COMMITTEE CHARGE/PURPOSE

The Systems Design Committee consisted of a diverse group of community professionals from different areas of child and family health, mental health, academia and social services. The committee was charged with the following:

- To develop a comprehensive model to address child, adolescent and young adult mental health issues.
- To identify the gap between the proposed model and the current structure in Orange County.
- To recommend an implementation strategy to migrate the current system to the proposed comprehensive one.

The committee has met nine times including a joint session with the Needs Assessment Committee on January 21, 2014. In an effort to provide additional information on the challenges within the current system for children's mental health services and to acquaint the committee with 'best practices', several of these meetings included presentations by community experts on: Wraparound Orange, Orange County Public School's services, Medicaid, the Spirit Project Software, Central Florida Cares and Infant Mental Health.

THE FOCUS/METHODS USED BY THE SYSTEMS DESIGN COMMITTEE

- Informational presentations and discussions on the specific program models in our community and on topics related to children's mental health.
- Discussions of community members' perceptions of the gaps in service(s).
- Review and discussion about 'best practice' models in place across the country.
- Discussions on the values and principles that should guide mental health services in Orange County.
- Discussions and development of a framework that can be utilized to develop a mental health care system in Orange County.
- Development of a preliminary logic model.
- Coordination with the Needs Assessment Committee to ensure integration of that committee's work into the final recommendations of the System Design Committee.

PROBLEM STATEMENT

The System Design Committee reviewed the assessment and recommendations of the needs and gaps in children's mental health in Orange County from the Needs Assessment Committee Report and a multitude of other sources. The primary message from this report is 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. The challenges inherent in developing an effective mental health service delivery system are not unique to Orange County. In fact, these same system problems across the nation prompted national attention in the in late 1990's and early 2000s and led to numerous national reports from the U.S. Department of Health and Human Services and the Surgeon General. Finally a Presidential call to action appeared in the New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America in 2003. Currently, mental health and substance abuse funding flows from the Substance Abuse and Mental Health Services Administration via the Department of Health and Human Services in the form of cooperative agreements, grants and federal block funding. Difficulties in creating a comprehensive, efficient and effective system are impacted by both system level issues as well as those problems occurring with the individual children/youth and their families. Some of the issues include the following:

Co-morbidity- Mental health problems in children, adolescents and young adults often exist co-morbidly with other mental health disorders as well as with other psycho-social stressors that may include; poverty, malnutrition, homelessness, and child maltreatment. The Department of Children and Families in its January 2013 report indicates "there are 146,724 children with severe emotional disturbances in families with incomes below 200% of the Federal poverty level" (p. 30). Families struggling to provide shelter and food do not have the time, energy or resources to obtain the mental health services needed.

Fragmented Data Collection - State level agencies collect different types of data in different ways, making comparison difficult. Some data collection is related to mental health, therefore system data often overlaps and is difficult to quantify. On a local level, the committee acknowledges that data collection related to mental health in children, adolescents and young adults is accumulated independently by service providers, not integrated or shared. The result is a daunting task to develop an accurate and updated overview on the state of child, adolescent and young adult mental health in Florida and Orange County. Interestingly, the committee discovered that this lack of coordination in data collection is reflective of the fragmented mental health services that appear to exist in the county and throughout the state.

A Limited Service Array - The Systems Design committee recognizes what many professionals in our community already know: that while we have some good mental health programs in our community, we need to develop a system that addresses more

effectively the diverse mental health needs of our children, adolescents and young adults and their families (Leon, 1999). Children do not operate in a vacuum and are dependent on their families for their emotional and psychological development and needs. Children's communities must have an adequate range of mental health services that meet those needs and parents should be able to access those resources easily and effectively.

Service Fragmentation - Managing a child's mental health needs is challenging enough without the added stress of services that are often fragmented, not family focused, not outcome driven and difficult to access. Families are systems presented with complicated problems that include obtaining medical, financial, educational and mental health services for their children. Unfortunately, families are often bounced from one agency to another in their efforts to receive those needed services.

Limited Access – Families experience a host of barriers to service access. Some communities in Orange County have minimal or no mental health services for children and adolescents within a reasonable location radius creating a lack of access due to transportation issues. Other barriers include; limited funding, waiting lists for services, cultural and linguistic barriers, days and times services are available, etc.

Differing population groups – The committee recognized that the populations to be served by the proposed Mental Health System of Care include those individuals from birth through age 24. The inclusion of young adults ages 19-24 reflects recognition by theorists that our society has changed and that young adults often for financial and psychological reasons either never leave home or often return home for support. Services to address a wide range of mental health problems among children and adolescents are needed.

Prevalence rates of mental health disorders - 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 Abuse 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.

Prevention vs. Intervention – Mental illness tends to be addressed from an intervention perspective. Equally important are efforts to address mental illness from a preventative model. Some individuals may be 'at risk' for mental health problems, while others are already affected directly or indirectly by mental illness. This requires that multiple strategies including public awareness campaigns about mental health, as well as preventative and treatment interventions be employed.

In addition to the aforementioned considerations, the System Design committee members deemed it important to obtain real-life challenges from the viewpoints of parents with a child that has a mental health disorder. Their thoughts and comments are indicated in ***Attachment A.***

Defining a Healthy Child/Youth and Family

Additionally, the Committee was asked to research the factors that contributed to the health and success of a child/youth and their family. A healthy child can best be described using the "40 Developmental Assets Framework" which identifies a set of skills, experiences, relationships, and behaviors that enable young people to develop into successful and contributing adults. Data has consistently demonstrated that the more Developmental Assets young people acquire, the better their chances of succeeding in school and becoming happy, healthy, and contributing members of their communities and society (http://www.search-institute.org/research/developmental-assets).

For families, the Center for the Study of Social Policy has identified five protective factors to strengthen families and therefore ensure children, adolescents and young adults have optimal environments to help foster optimal development across the lifespan (http://www.cssp.org/reform/strengthening-families/the-basics/protective-factors).

This approach is coined "Strengthening Families" and includes five protective factors: parental resiliency, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children.

Theoretical Concepts/Frameworks Guiding the Recommendations

The Systems Design Committee determined that developing a mental health system of care requires that a system integrate all the aforementioned factors as well as the perspective that there is a 'total' child, adolescent or young adult needing mental health services. Committee members agreed that it was important to identify key principles to guide decision-making and development of a comprehensive model for existing and future children's mental health services in Orange County. The committee members reviewed national and state publications, websites, academic journals and private foundation reports (some of which are identified in the reference section). The goal was to determine which models have the best outcomes for children, youth and young adults with a mental health disorder. In essence "what does the perfect system look like?"

The Systems Design Committee has determined that two types of perspectives are needed: one to focus on the policy and administrative level and the other to focus on the parental/family perspective level. The perfect system in Orange County is defined in this context.

System of Care – A model for policy and administration

In the late 1980's nationwide discussion amongst communities and agencies interested in transforming their child and adolescent mental health services led to the national adoption of the 'system of care' framework that addressed the complexity of mental health problems in children, adolescents and young adults. Since 1992, the federal Comprehensive Community Mental Health Services for Children and Their Families Program (or the Children's Mental Health Initiative, CMHI) under the Substance Abuse and Mental Health Services Administration (SAMHSA) has invested resources in implementing the system of care approach in communities across the nation. With a strong history of demonstrating the effectiveness of this approach, SAMHSA has shifted their approach towards strategies for expanding systems of care throughout states, tribes, and territories (SAMHSA, 2011).

The system of care approach has reshaped 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 many adult-serving systems.

Although the system of care approach continues to evolve to reflect advances in research and service delivery, the core values of community-based, family-driven, youth-guided, and culturally and linguistically competent services are widely accepted. The guiding principles calling for a broad array of effective services, individualized care, and coordination across child-serving systems are extensively used as the standards of care throughout the nation.

DEFINITION

A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

CORE VALUES

Systems of care are:

- Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
- Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
- Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports.

Additionally, System of Care is further defined with a core set of guiding principles that set the foundation for the work of communities that are implementing the model. ***(See Attachment B).***

A System of Care approach is effective and consistently shows the following:

- Children and youth have demonstrated improvements in clinical and functional outcomes, increases in behavioral and emotional strengths, reductions in suicide attempts, improvements in school performance and attendance, fewer contacts with law enforcement, reductions in reliance on inpatient care, and more stable living situations.
- Caregivers of children and youth served within systems of care experience reduced strain associated with caring for a child or youth who has a serious mental health condition, more adequate resources, fewer missed days of work due to the mental

health needs of their child, and improvement in overall family functioning (Manteuffel et al., 2008).

- The system of care approach is a cost effective way of investing resources by redirecting funds from deep-end services (inpatient and residential treatment) to home- and community based services and supports (Gruttadaro, Markey, & Duckworth, 2009; Maine Department of Health and Human Services, 2011; Maryland Child & Adolescent Innovations Institute, 2008; Manteuffel et al., 2008).

As a result of these positive outcomes, SAMHSA launched a new effort to further this progress by providing funds to states to develop comprehensive strategic plans for widespread expansion of the system of care approach so that more children and families can benefit (SAMHSA, 2011). It should be noted that Orange County Government is a current grantee for a System of Care Cooperative Agreement from SAMHSA since September, 2009, and has titled the project, Wraparound Orange.

The system of care framework is intended to be used as a foundation for mental health services that includes a collaborative of coordinated services across agencies and should be a part of evidence based services (Hernandez & Hodges, 2003; Stroul, 2002), leading to the second model for Orange County.

Family support model – focusing on the entire family system

Children clearly function within the context of their families, neighborhoods/communities and peer systems. It is the family system especially that attends to the individual's physical, social, emotional, cognitive and interpersonal needs as early as infancy and through young adulthood. Families set the tone for our initial interest in learning, our early perceptions of the world and others around us and have the major responsibility to set a good foundation and environment that will foster resiliency and good mental health functioning for years to come. However, it is clear to health and mental health care providers and to educators that families often lack the resources, motivation, and knowledge to fulfill this function for every child. The importance of following a family support model in mental health service delivery that will empower parents and provide the needed resources so that parents and families can help develop resilient and healthy children is paramount to any community

(Leon, 1999). Services based on a family support model recognize that often parents and families are overwhelmed with the responsibility of raising children while trying to maneuver complicated health, mental health and social service systems. Parents increasingly struggle to find the most appropriate health and mental health services for

their children, adolescents and young adults. To achieve success mental health providers must embrace the total child and family and therefore identify ways of developing and implementing services that address the health and mental health needs of this population.

The Adverse Childhood Experiences (ACE) conducted as a collaborative process between the Centers for Disease Control (CDC) and the Kaiser Permanente's Health Appraisal Clinic in San Diego, the largest study to date that has examined relationships between childhood abuse and its impact on the well-being of the child through adulthood (http://www.cdc.gov/ace/). The findings strongly correlated that early childhood experiences predispose individuals not only for mental illness but for poor quality of life, health problems and even death (Whitfield, 1998). Young children, adolescents, and young adults cannot be treated in a vacuum as they function within the parameters of the family system. It is therefore vital that a mental health delivery system take into account major principles from a family support or family focused model. These components include:

- Providing services across the lifespan from prenatal to age 24
- Strengthening the family system
- Strengths perspective and empowerment
- Integration of Service -The Bio-Psychosocial Approach
- Collaborative partnerships
- Neighborhood Based and Family-Friendly Services
- Fiscal support
- Identification of formal & informal community based resources & good case management services

The Family Support model provided a guide to the Committee on the types of resources and services as well as how those items should be used in service delivery and is a foundation for the Committee Recommendations. For further information ***See Attachment C.***

National Outcomes for System of Care

Coordination of services and resource utilization by way of a System of Care model will guarantee that those served are central to the process and that the defined and credentialed service deliverables are effectively used to maximize good outcomes based on both data analysis as well as from the perspective of those served by the system. Such an approach maximizes resource utilization, avoids duplication, decreases fragmentation, increases capacity to serve more youth, and is outcomes accountable. Carefully

coordinated care under a wraparound model with full vestment of the youth and families will lead to less use of costly higher end services. Such savings could then be used to further expand the volume of youth and families served. These types of outcomes have been predicted for or attained by other similar approaches around the nation, even though they vary in overall design, targeted groups, and geographic organizational scope: California's Proposition 63, Wraparound Milwaukee, and our local Wraparound Orange.

California's Proposition 63 - A study of comprehensive family therapy approaches centered around and driven by the youth and family's needs for youth in the juvenile justice system reduced re-arrests by 50% (Blueprints for Violence Prevention 2004). That study calculated the cost-benefit to be $13 saved for every $1 spent on functional family therapy intervention as a prevention targeting at-risk youth over just a three month period on average. Ongoing follow-up with the youth and families controlled recidivism.

More recent analysis of the Proposition 63 comprehensive services outcomes showed significant reduction of psychiatric emergency interventions and psychiatric hospital admissions in all age ranges (UCLA Center 2011) and there were significant reductions in homelessness rates among families entered into comprehensive holistic programs (UCLA Center 2011). There were dramatic reductions in arrests for transitional youth age ranges (adolescents), decreases in school discipline rates, and positive trends in education outcomes related to academic performance (UCLA Center 2011).

Wraparound Milwaukee - The Wraparound Milwaukee ambulatory, community-based, and family-centered approach reduced the need for youth residential treatment by 60% and psychiatric hospital admissions by 80% (Kamradt 2000). Significant cost savings also occurred with the wraparound model targeting youth in juvenile justice as it reduced arrests by 34% on average per youth served.

Wraparound Orange - A significant reduction in functional impairment of the youth and families was also achieved. In Orange County Florida, Wraparound Orange outcomes data showing a reduction in arrests from 67% to 11% over a 12 month period.

Proposal for a Mental Health *Systems of Care* Design for Orange County Florida

The report of the Systems Design Committee of the Orange County Youth Mental Health Commission endorses the *systems of care* methodology with a structure similar to but not identical with examples illustrated by Pires (1996). The Systems Design Committee endorses the wraparound methodology as key to the design. This report to Orange County

by the Committee serves as a first-step reference for the local, regional and state stakeholders in the building process of the *systems of care*. In keeping with the key elements that the Committee has defined, the following key system constructs are proposed (also see figure 1):

The Committee further concluded that holistic methodologies are central to the foundation of this system and it absolutely must be a youth- and family-centered entity driven by the needs of the youth and families. The top-down model of provision of care must be avoided. The concept is that if there is failure in an outcome, the youth or family did not fail, but rather the *system of care* failed them.

To be successful and effective such a *system of care* requires a coordinated network encompassing a very broad array of services and supports with high fidelity integration of those interventions. It also must be individualized and incorporate the youth and family into a working partnership with the system. Building the system is a multiagency undertaking utilizing a robust involvement of community level partners. Moreover as Pires (2002) concluded, "Building systems of care is a multifaceted, multilevel process. It involves making changes at state, local and even neighborhood levels. It entails changes at policy and service delivery levels." Stroul (2002) has pointed out and Pires (2002) confirmed that *system of care* is the framework and not the delivery model *per se*. Each community has unique as well as similar needs and each has its varying sets of resources, thus systems are not alike in design, but are comparable in values and concept.

MISSION STATEMENT – *See Logic Model*
The Orange County 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 STATEMENT – A community of resilient youth and families well equipped to deal with the stress of life and enjoy empowered, independent, healthy and productive lives. (Wraparound Orange)

SYSTEM OF CARE COMPONENTS

- An Interagency Team (Head Agency for the Program)
    - Management Network oversight body with mandate and jurisdiction to provide mental health services.

- Development of strategic planning initiatives using a collective impact strategy for improving Orange County outcomes.
- Representation from important community sectors, including juvenile justice, child welfare, public education, mental health and social services agencies, and experts in mental health care as examples.
- Promotion of the high fidelity team approach, intersecting with the wraparound model of community-based care.
- Responsible for Management Network administration, funding, credentialing, quality assurance, and quality improvement.

Authority and Governance

The *system of care* requires high-level authority to carry out its mission, a defined champion or set of champions to see it through, a qualified and insightful governance body or board, and a dedicated staff with adequate funding and resources. The Board must have particular skills in securing buy-in from a diverse set of providers, stakeholders, payers and government. They must be skilled in building partnerships and coalitions. A significantly large number of existing services and care entities must be recruited to join the *system of care* in addition to those already contracted with Wraparound Orange to provide the needed support network.

Systems Management

The Orange County Youth Mental Health System of Care authority will then begin at the county government level and will include an appointed governance body with dedicated resources supporting its function. Ideally the governance body will include key local and county stakeholders from the entire child serving systems (juvenile justice, child welfare, special education, community mental health, health and managed care organizations at a minimum). The governance body and its leadership will assume all responsibility for the conduct of the system, management of the budget, assessment of service providers, quality assurance, quality improvement and shared liabilities. The organization will function much like an Administrative Service Organization. Agreements and definitions of participation, risk-sharing, and all matters of governance will be the responsibility of the Board. It is also responsible for credentialing standards, the credentialing process for, and endorsement of resources within the community (see figure 1).

A skilled mental health Systems of Care Implementation Team hereafter referred to as the Team, of dedicated staff will be formed under the administrative leadership. Support staff will be defined for leadership, administrative duties and quality improvement. The Team

will report to the Management Network. The Team leader will be responsible for administration of the team, including hiring, evaluation, promotion, and dismissal of team employees. Budget and data management, oversight of grants management, and outcomes data collection and analysis will be among the responsibilities. The Team will be responsible for management of the Access Portal for youth, young adults and families seeking care or referred for care using a behavioral health navigation model. Behavioral health navigation staff will be utilized to initiate services with duties that include assessment of need, identification of youth- and family-stated needs, identification of evaluation and care services as required, and to begin the wraparound management within the systems of care for each youth and family. This will include identifying resources within the Wraparound sphere (see figure 2), such as peer and family groups and other mentoring services organized under the Team that are individualized for the specific youth and family by case analysis. The Team will utilize a robust software system to arrange care plans and make referrals within the sphere of community resources and providers (see figure 2).

- Access Portal to the System of Care
  - Provide for a centralized intake center
  - 24/7 services with phone and internet access points. Possible use of 211

Portal of Access to Care

There will be a single point of *systems of care* access for youth and families seeking or referred for service or care. Behavioral health navigators, case managers and/or wraparound facilitators depending on the needs of the child and family will be assigned to each youth. Appropriate levels of supervisory staff will also be appointed for administrative and personnel management and oversight of the process (see figure 1). The principles embodied in the already successful Wraparound Orange will be central to this proposed expansion of *systems of care*. This proposal incorporates the core values of Wraparound Orange, addresses the concerns of the Commissions' Needs Assessment Committee, and seeks to expand those on a much wider scale to address any youth, young adult and families challenged with mental health concerns or substance dependency. The core values covered by Wraparound Orange and also essential to this systems design are echoed in the mission statement of this document and include; family-driven, youth-guided, culturally and linguistically-competent, strengths-based, comprehensive, community based individualized, integrated, competent, respectful, outcomes-based, and evidence-based and focused on early prevention and intervention. It cannot be overemphasized that the youth and families must be empowered as meaningful partners in their participation in care

giving interventions. Those served must be central to the process (see figure 2). The Portal of Access will be through the internet, by phone or in person. A computer tablet and hand-held device app can also be developed. Entities referring cases (see referral section below) will provide contact information for those they serve as it is available. A public service campaign will be needed to bring the *Systems of Care* in Orange County to the attention of its citizens. A three-digit hotline phone number can be contemplated for future access.

Referrals of Youth and Families from Other Sources

The systems of care will be designed to accommodate referrals from a significant number of important sources (see figure 1). These include but are not limited to State and County Agencies, Department of Children and Families, Departmental Directors, Public School System, private schools, university health centers, daycare centers, domestic violence programs and centers, child abuse programs, the legal system, the juvenile justice system, Department of Corrections, medical practices, emergency departments, mental health agencies (including agencies both within and outside the systems of care network), social agencies and faith-based organizations. The Access Portal function for these referrals to the *system of care* must be timely and seamless and must have effective two way communications set up with the referring entity by the Care Management Team. Once again, a well-designed, on-line software resource will greatly assist this reporting.

The Systems Design Committee believes that the specifics of a *system of care* design presented above and diagramed in figures 1 and 2 will address many of the major issues identified by the Needs Assessment Committee, including the disarray of mental health services already available in the community, the lack of coordinated care, the lack of access that is functional and responsive to needs of those seeking help, and poor communication between multiple levels of care provision.

- Coordination and Navigation Service
  - Establish a network of Behavioral Healthcare Navigators
  - Work with current care coordinator type entities (Targeted Case Management, Dependency Case Management) to ensure adoption of system of care values.

System of Care Network: The Provision of Services

The care and services network will be expected to be comprehensive, diverse, and accommodating in its responsiveness to the *system of care* needs. Members of the network must agree to meet quality and performance standards set by the system under the

governance of the Management Network and the network members must agree to maintain those standards and to be evaluated by way of prospectively designed outcome measures and youth/ family satisfaction rates. Providers in the coordinated network must agree to take youth and families identified to them for services by the *systems of care* Team. Reporting must be bidirectional with open communications in a fashion completely transparent to the youth and families (see figure 2). Once again, an on-line system to coordinate care, set referrals and manage outcomes data is essential to address systems complexities. A *system of care* wraparound management process with the goal of high fidelity requires complex referral and scheduling methods, since any set of referrals or interventions are individualized. Tracking of referrals, case management, and outcomes data collection and analysis would be severely limited without an electronic record. Newer software products with internet-based interfaces have been developed and can be tailored to the specific needs of the *system of care*. The breath of local agencies and services that are recruited must be comprehensive in the participation as referral sources for youth and families within the *system of care*. This process was begun under the leadership of Wraparound Orange and is working well. They have an excellent starting base of a referral network of services that already includes 6 Mental Health contractual agency partners and two business contractual partners. The vision of this proposal is that those resources will be comprehensively expanded in numbers, complexity, and scope, but maintaining the same wraparound philosophy.

Bidirectional reporting and updates between the Team and the resources identified for the youth and families are extremely important to the proper functioning of any mental health *system of care* undertaking. The robust software system of tracking and reporting can be used for this bidirectional communications and serve as a platform for documentation. Additional proposals of importance for the *system of care* include preventative services, early risk identification initiatives, prenatal and infant identification methodologies, and a mobile emergency response system. Other modular system of care services specific for these areas should be developed in a methodical fashion. Lastly, a 24/7 Mobile Mental Health Crisis Response Team is a major goal moving forward.

- Provide a Credentialed Network of Mental Health Services, Providers and Agencies
    - Management Network sets credentialing standards for all entities within the network.
    - Listing of resources and services access according to the plan of care for the child, adolescent and young adult and his/her family.

- Bidirectional coordination and reporting between the service entity and Management Network and Team (care management coordinators).
- Entities must agree to the principles inherent to a unified system of care.

Community Resources, Agencies and Partners

Mental health care providers, healthcare providers, substance abuse providers, schools, child welfare, court administration, juvenile justice and many other intervention and support organizations will be recruited to join the *system of care*. Referral requests will come from community care managers in partnership with the youth/young adult and family for resources targeted toward the specific need of the youth/young adult and family. The approach will be structured after wraparound concepts in that the services and interventions are wrapped around the central needs and wishes of the youth/ young adults and families and driven by them in great measure. A matrix of services within the community will be developed and managed using the mentioned secure on-line software based methods. The system of care will allow the resources of these diverse entities to be pooled to maximize their utilization in benefit of the youth and their families.

- Diversify/Expand the service delivery array in Orange County
  - Establish a Mobile Crisis Team that allows for 24/7 crisis response to children, youth and young adults experiencing a mental health crisis.
  - Establish a Children's Assertive Treatment (CAT) Team for children/youth/young adults.
  - Expand wraparound service delivery to youth and young adults. (Currently teams serve only 0-12).
- Focus on Services Across the Child/Adolescent/Young Adult Life Span
  - Consideration of parent education and family work during the prenatal period.
  - Focus on the parent-child relationship during the 0-5 age group.
  - Early intervention and identification from birth through 5 years of age.
  - Attention to school age children.
  - Develop age appropriate services for adolescents & young adults.

The committee also acknowledged that there are services needed at the prevention and intervention levels and that those will require different approaches.

- Focus on the Family
  - While there was some family participation in the initial meetings, the committee identified the challenge of not having family/parent perspective on the committee. This participation is valuable as it provides the 'consumer' perspective and efforts to include parents/families will be made.
- Culturally Sensitive & Competent Services
  - Develop & provision of services that take into account the following:
    - Race/ethnicity
    - Religion
    - Sexual orientation differences among parents, children, adolescents & young adults
    - Attention to growing populations of diverse families in Orange County (Latinos, Haitians, Other Caribbean Groups & Asians)

It is important to note that Orange County Florida is a diverse community and a component of an effective system must take into consideration the cultural and linguistic needs of an ever-changing population. Committee discussions identified that the development of services must take into account the diversity of children, adolescents and young adults in different areas, recognizing that different mental health services, approaches and interventions will be needed depending on the developmental stage of the child/adolescent/young adult. Areas of diversity include:

- Chronological age
- Stage of development
- Racial/ethnic/cultural differences

- Systematic Outcomes-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.
  - Develop a specific set of core quality measures for those goals and objectives similarly tailored after the Wraparound Fidelity Assessment System.

- Establish a tracking and data collection system, ideally within a unified information technology framework.
- Data analysis according to goals-based, strengths-based, and needs-based approaches.

Develop/Monitor Community Outcomes

As stated there is difficulty in obtaining reliable, accurate data on the status of child mental health in Orange County due to the fragmentation in the collection of data by various service providers not only in Orange County but also across the state. There is a need to implement a systematic effort to access as much data from various sources that will illuminate additional gaps in mental health services and it is recommended that the Implementation Team of the Youth Mental Health Commission continue to search out, identify and collect this data. The Needs Committee identified the following indicators and established base-line data for moving forward. ***See Logic Model - Problems/County Child Data 2012/2013.***

System design objectives for impacting these data points are as follows:

- Increase use of Civil Citation programs
- Decrease child arrests for ages 5-10
- Reduce school suspensions/expulsions
- Reduce number of children being removed from Voluntary Pre-Kindergarten (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

Integration of Software and Database Management

The System Design Committee recommends the development of a robust and intuitive on-line software database that will virtually link all mental health/children serving organizations, the Judicial and Law Enforcement systems, and the families being served in Orange County (See Diagram 1). This on-line system would serve as the single point of entry for families to be linked to mental health services and treatment, and at the same

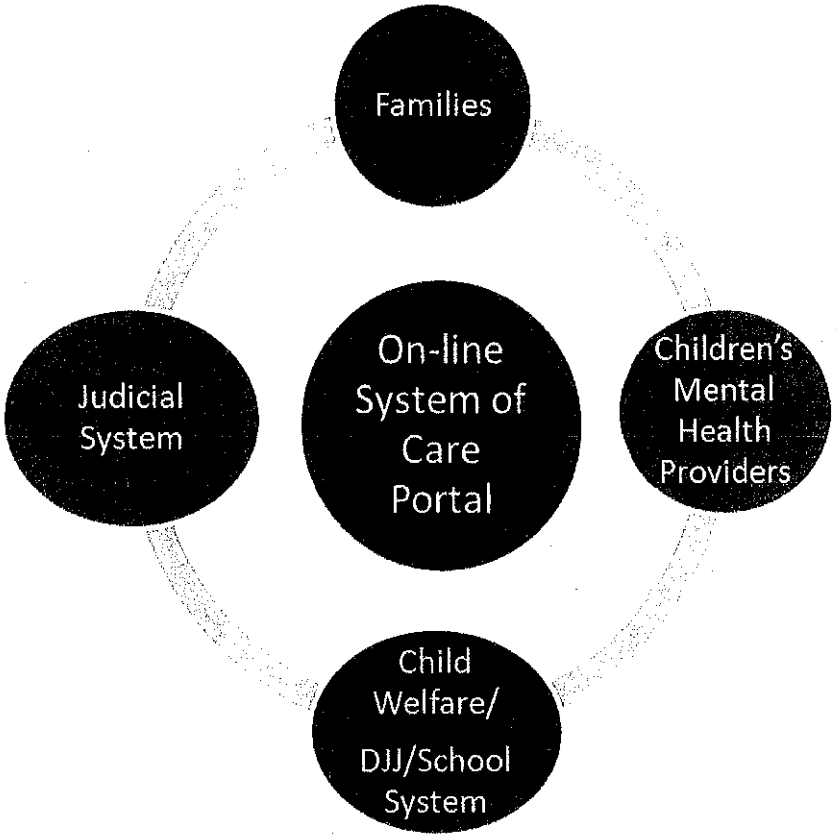
time will allow for cross system communication with all organizations and providers within the system of care.

The committee envisions an on line portal that would enable the system of care participants to:

- Improve communication, connect-ability, and accountability.
- Develop uniform on-line referral, assessment, and consent forms.
- Enable real time electronic referrals to mental health and other service providers.
- System of Care partner agencies would be able to upload to the system their array of services, eligibility requirements, and availability.
- Allow families access to navigate the system for available services tailored to their child's needs, and to provide the most geographically convenient service locations.
- Real time tracking of families as they navigate through the system of care.
- Development of an on line scorecard that highlights the critical outcome measures for the system of care partners.
- Shared data hub for system of care providers, and state and county governmental agencies.
- Leverage mobile communication devices such as smart phones and tablets through the development of an app that would link both professionals and families to the on-line portal.

The success of the proposed system of care recommendations is contingent upon the development of this integrated software database. Our committee further recommends that the Management Network entity serve as the "oversight and management" body for the proposed on-line software database. This would include serving as the system gatekeeper to manage access to the on-line database, tracking credentialing of system of care providers, and monitoring overall system of care outcomes.

Diagram 1



- Continuation of Research Efforts
  - Develop ongoing research efforts that will identify and examine evidence based interventions that can be replicated within the system of care.
  - Develop and implement an ongoing program evaluation component that will evaluate the efficacy of the overall model as well as assess the effectiveness of interventions and approaches utilized by various providers.
  - Develop a system of data collection that will yield ongoing and updated data on child mental health in Orange County—this can be used for various purposes that include seeking legislative support and obtaining grants for additional child mental health services.

The Role of Ongoing Research & Program Evaluation Considerations

An effective system of mental health services requires the integration of ongoing research and program evaluations. This component will ensure:

- accountability and fidelity to model outcomes by all providers in the network,
- evaluation, identification and translation of 'best practices' that can be utilized by other providers and,
- generation of new mental health research information that can be shared with the local community and across the country.

One of the major challenges for the Systems Design committee and for our community in general is the lack of a coordinated effort to provide an overview with statistical information on the mental health state of affairs in the county and throughout Florida. Research and program evaluation efforts will be most helpful in the following ways:

- Providing needs assessment information on mental health services provided through the model proposed.
- Providing a comprehensive overview on mental health in the county—this can then be used to advocate for increased services, legislative dollars and to obtain external funding grants to augment mental health services within the proposed model.
- Provide a partnership between a local university and other Network partners to begin collaborative efforts to secure external grants for enhancing components of the model with the specific goal of soliciting grants that address specific age groups and problems.
- Provide a venue for information that other providers may utilize to enhance other related services in the county. Orange County has the opportunity to distinguish itself as a county that provides a 'clearing house' of vital information on the mental health of children, adolescents and young adults.

The integration of ongoing research and program evaluation initiatives within the proposed model has great potential to increase the collaborative partnerships within the county. Most importantly, these efforts will ensure the quality, fidelity and accountability of the essential program components inherent in the proposed model. As a community, we know we have good programs and services, however, we lack the objective, outcome driven and research grounded information to substantiate those mental health contributions. This component of the model will ensure that we are always assessing the outcomes in the model and making improvements where necessary to ensure that our children, adolescents, young adults and families receive the most effective, outcome driven, evidence-based, accessible and appropriate services to address mental health problems.

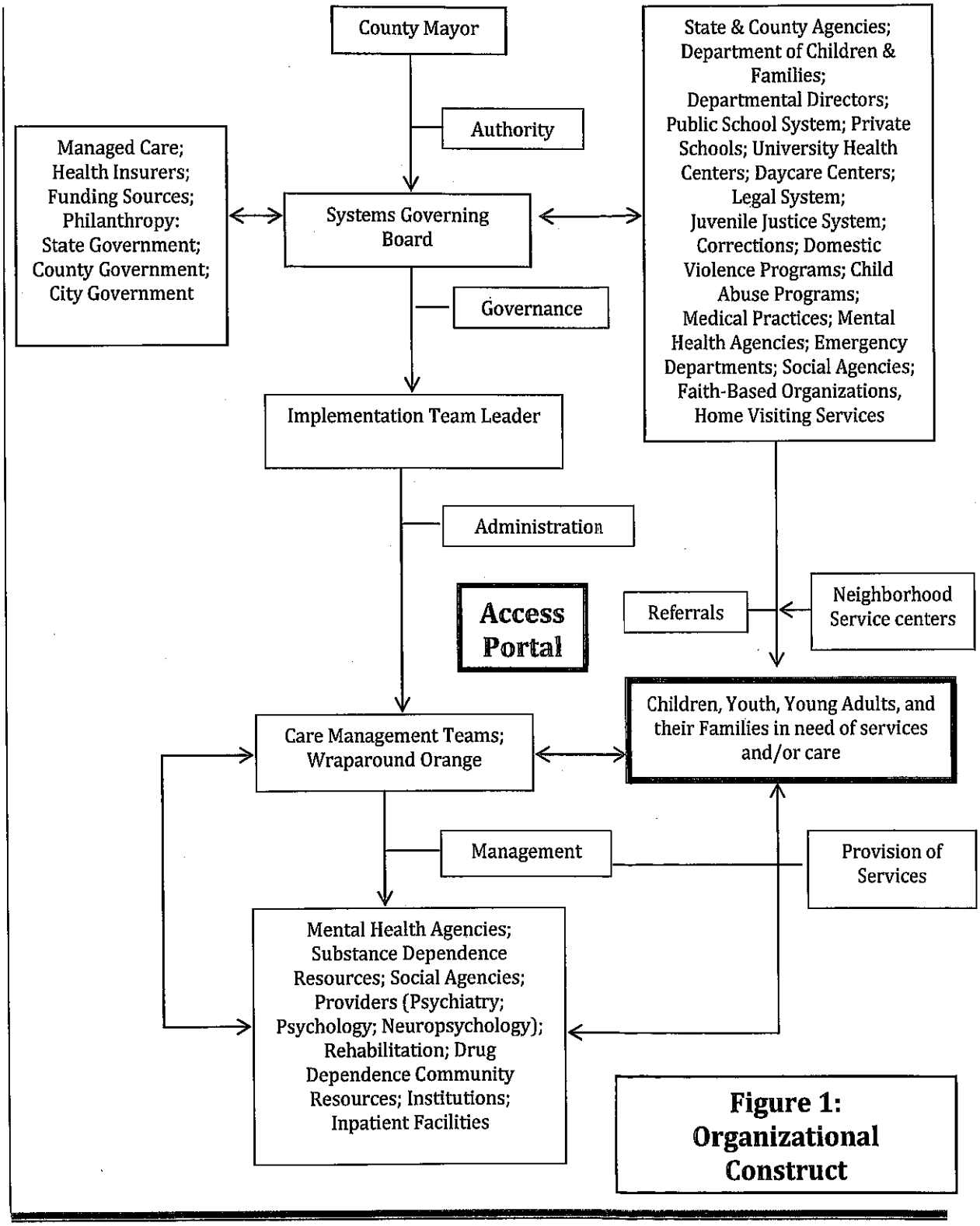


Figure 1: Organizational Construct

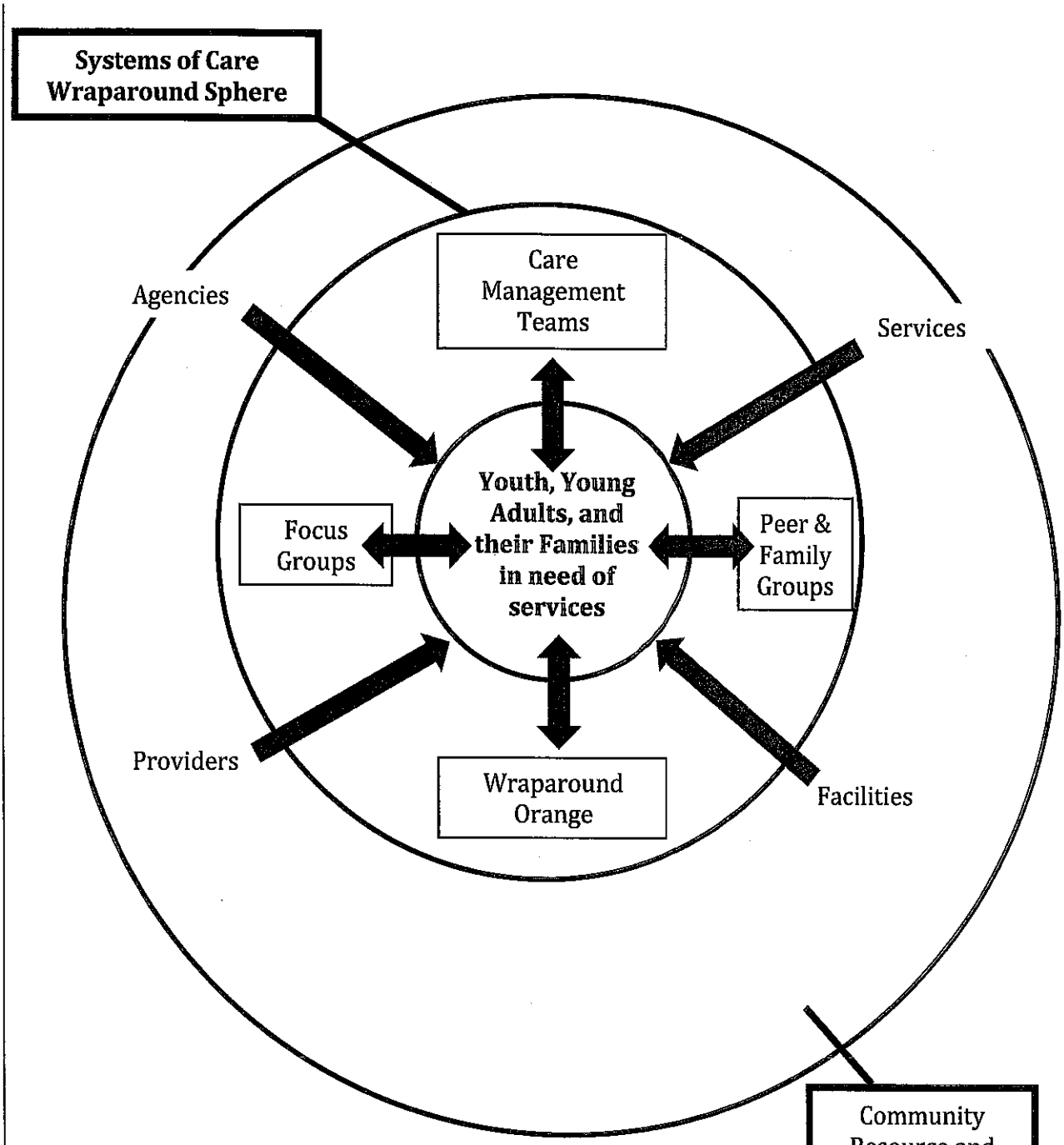
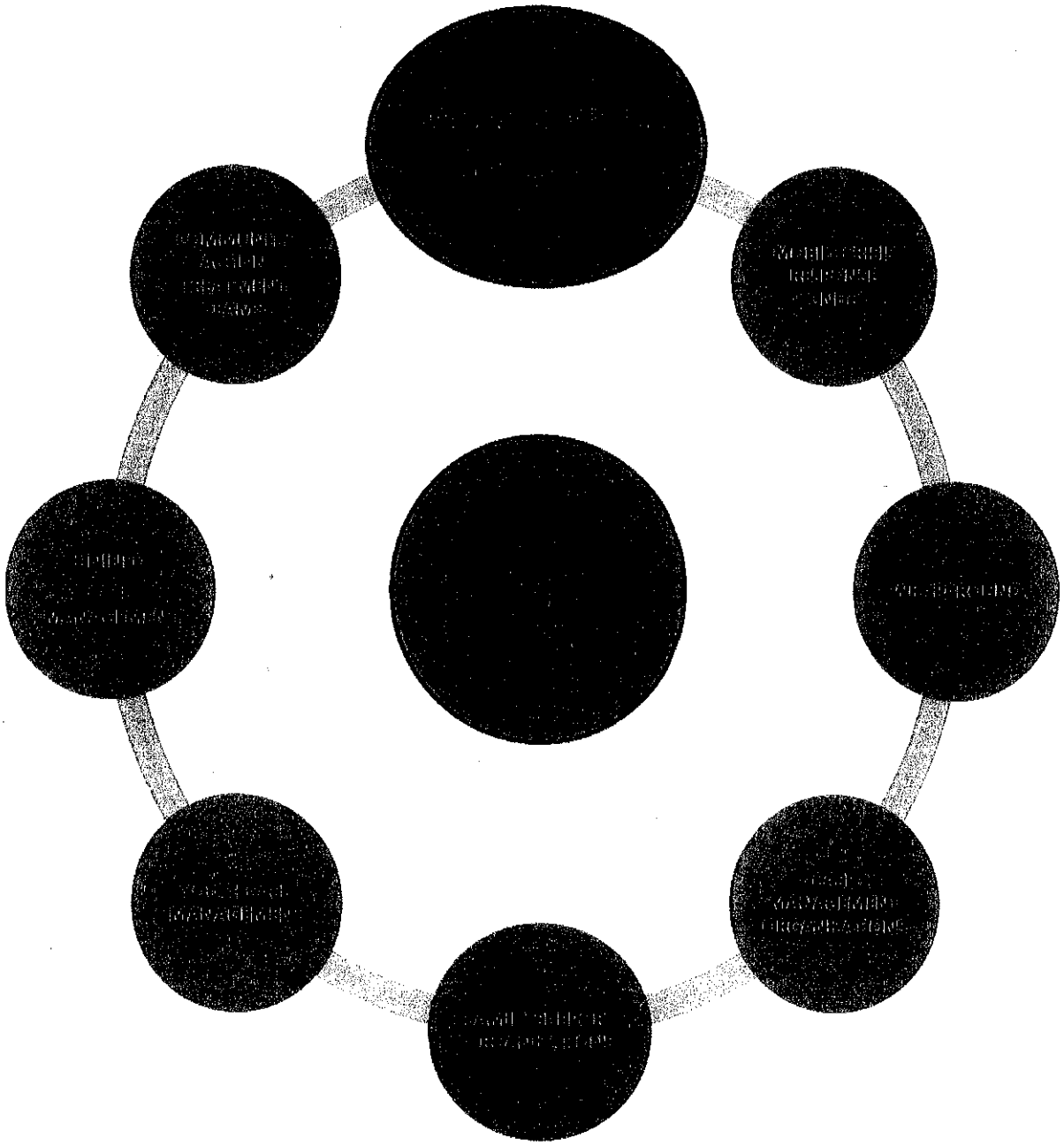


Figure 2:
The Spheres of the Systems of Care

ORANGE COUNTY SYSTEM OF CARE
Supports for Families



Supports for Families

Short Term Goals - Local Level (6 months to12 months):

- Establish a Youth Mental Health Commission Management Network/Implementation Team comprised of policy/decision makers from Orange County Government dedicated staff, Department of Juvenile Justice, Department of Children and Families, Community Based Care of Central Florida, Central Florida Cares (Managing Entity), and Orange County Public Schools at a minimum to develop a Strategic Plan based on the recommendations from all of the Committees. It is expected that this team will meet on a monthly basis. ***(Immediate Goal)***
- Establish a centralized database and call in center for resources
    - Complete a service mapping to understand what is available in our community, what are the gaps, where are services located, what is being duplicated, etc.
    - Establish a call in center with designated staff that will be used as the point of entry for disseminating and coordinating referrals within the network, (211 is a possibility).
    - Create the call in center as a brand (educated the community, referral sources, and leaders, determine navigation paths for families, establish a feedback system for referrals, track referrals and data, develop standard operating procedures and forms).
    - Develop and maintain a database.
    - Develop marketing materials and educate the community.
- Create a successful county youth mental health Management Network with leadership from Orange County Government to develop and implement the System of Care model with components outlined in this report (Focus initially on behavioral health care navigation and a single point of entry with 24/7 availability).
    - Begin to develop a strategic plan for the mental health delivery system.
    - Develop specific outcomes for each developmental age group, common ones and family ones.
    - Enhance the mission and vision statements.
    - Enhance the logic model.
    - Begin conversations with managed care companies on their buy in and participation in a mental health service system.

  - Begin to identify the Management Network, database provider, etc.
  - Begin to break down the special needs and services required by each developmental age: preschool, childhood, adolescence & young adulthood.
  - Consider developing a research, training and public relations component to begin to work on a new vision & collection of data from the beginning.
- Implement a countywide system of feedback and complaint resolution for families and providers through the Management Network.
- Implement an information technology linkage to enhance evaluation activities and track outcomes at the clinical, program and cross-system levels.
- Increase training for families, providers, school district personnel and community stakeholders, include Crisis Intervention Team – Youth training for Law Enforcement.
- Provide ongoing, cross-system training and technical assistance to network providers regarding System of Care principles.
- Increase trainings for families regarding the System of Care and the education system.

Long Term Goals - Local Level (12 to 24 months and ongoing):

- Diversify mental health and substance abuse services available to children, youth and young adults in our Community to include wraparound, peer support, evidence based family interventions, respite, mentoring (see Attachment G, crisis response, etc.).
- Implement Community Action Teams (CAT) and Mobile Crisis Units to de-escalate crisis and reduce Baker Acts and arrests.
- Expand Wraparound services for youth and young adults up to the age of 24.
- Implement Family Support Models in the county to include Multi-Systemic Therapy or Functional Family Therapy.
- 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).
- Establish a dedicated Children's Mental Health funding source.
- Reduce stigma around mental health needs and increase awareness.
- 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.

- Expand services for 0-5 population (see below)
- Expand services for 18-24 population (see below)

Short Term Goals – State level (6 months to12 months):

- Educate state level leaders and legislatures in System of Care and the components desired by Orange County.
- Establish a strategic plan around financing.

Long Term Goals State *(12 to 24 months and ongoing):*

- Lobby for Medicaid expansion.
- Work with private insurance companies to diversify the mental health and substance abuse services available in Orange County and support System of Care.

Recommendations for Systems Design Committee re: 0-5

The Systems Design Committee recognizes the special needs of prenatal to birth to 5 years based on research and data around Infant Mental Health. Since pregnancy effects are felt long term in a child, efforts should be made to educate the public. Initial focus should be on those in their child bearing years and include information on the importance of the pregnancy time period on the child's long term physical and psychological health into adulthood. When a family accesses any point in the social service system, they should be treated holistically and follow up should occur to ensure compliance and ensure they received the help needed. The following recommendations are established to enhance service delivery for this population:

- 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)
    - The importance of the pregnancy time period which impacts every developmental stage to lifelong physical and emotional health and productivity.
    - The importance of bonding and early literacy and stimulating your child in ways other than television and technology.
    - The importance of choosing a quality caregiver for their children and continuity of care.

- Create professional education programs that inform:
  - 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)
  - Ensure all those dealing directly with families are trained on mandatory reporting of suspected child abuse. (short term—within 1 yr)
  - 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
  - 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)
  - 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
  - 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)
  - Offer parenting classes/support groups for parents at all stages of childhood that are widely accessible and affordable. (long term—within 2 yrs)
  - 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.)
  - Implement the practice of all new families receiving at least one home visit postnatally within six months to offer reassurance, ensure all is proceeding normally and offer reassurance. (Long term—within 18 months-2 yrs./ongoing)
  - Utilize family liaisons to follow up with parents entering any point of the system. (Long term – within 18 months and ongoing)
  - 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)
    - 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.
    - Provide incentives for early learning sites to fully implement a pre/post assessment that incorporates infant/toddler mental health indicators.
    - 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.
    - 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 Kinder Konsulting)

Recommendations for Systems Design Committee re: Expand Services for 18-24 population

An overview of the types of services available to this population and the difficulties with understanding payer sources, see Attachment E.

- 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

- Better coordination/communication of services between departments (adopt no wrong door philosophy).
- Use of a Management Information System to manage/coordinate student data.
- Utilize case management on campus via CAPS program.
- Abolish "session" limits of 12 sessions per year (offset costs by using by billing insurance).
- Offer crisis services and use peer support via a student run volunteer program.
- Provide 24/7 online and hotline suicide services with peer support using IMAlive or creating a volunteer student network.

OTHER CONSIDERATIONS

Children, Adolescents & Young Adults with Disabilities

When considering the 'total' person, other types of challenges that often accompany mental health problems must be considered. Other types of disabilities experienced by children, adolescents and young adults in Central Florida can include physical, developmental, cognitive or mental challenges that can affect normal functioning and stress out family systems. Children with these types of limitations require a service approach that is even more comprehensive, interdisciplinary and well-coordinated since the family now has to manage more than one debilitating condition. Health and mental health providers have the opportunity as well as the challenge of helping parents and family systems cope with and appropriately address all of the conditions that the children, adolescents and young adults face, while also paying attention to the special services that the overloaded family system may experience. Case management in these situations will be essential to a good system of mental health services since these multidimensional problems will require a multi-systemic approach, utilization of community resources and the expertise of various providers.

Dual System/Cross-over Children, Adolescents & Young Adults

Many children, adolescents and young adults receive services simultaneously or at different points from various systems that may include the child welfare system, juvenile justice and criminal court. These individuals often present with substance abuse problems as well as criminal behaviors. There is not sufficient coordination between the agencies to comprehensively address the problems faced by this population and their

families and often when one system is not able to provide adequately for the individual, the other system is engaged. The committee recognizes the need for increased coordination between agency providers and the importance of integrating a collaborative partnership between the agencies that provide services to children, adolescents and young adults in Orange County.

In Circuit Nine, there is a sustained effort to develop a systems approach and promote the local level coordination of services for youth that have crossed over into multiple agencies. There is an operationalized interagency agreement between The Department of Children and Families (DCF), The Department of Juvenile Justice (DJJ), Agency for Persons with Disabilities (APD), Agency for Health Care Administration (AHCA), Department of Health-Children's Medical Services (DOH-CMS) and Community-Based Care of Central Florida (CBCCFL). This level of coordination of services is referred to as Local Review Team (LRT). The LRT provides an opportunity for enhanced system coordination and opportunities for family and youth voice.

Additional Attachments

The Systems Design Committee has attached additional information that may be used as a guide for future strategic planning of a Management Network and/or Implementation Team. The Surgeon General's report, Attachment D, provides a wealth of information on the types of goals and strategies that should be used in a system redesign. Attachment E-payer sources for the youth population of ages 14-24 provides an overview of the current funding structure for this group as foundational information. Currently there are numerous "Neighborhood Centers for Families" in operation across Orange County that has the potential for service expansion to meet the recommendation of neighborhood service hubs. Attachment G provided by Youth Advocate Programs demonstrates the value of utilizing Youth Mentoring in the Children's Mental Health arena.

Conclusion

Throughout this report the Systems Design Committee has identified the importance of a the development and implementation of a well-integrated Children's Mental Health service delivery system based on a System of Care philosophy. The Committee believes Orange County has the resources, initiative and experience to impact our system for the betterment of children, youth, young adults and families in Orange County. It is highly recommended that implementation of this plan under the leadership of Orange County Government occur swiftly and committee members believe the community is willing and able to carry-out the objectives necessary for success.

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Attachment A

A FAMILY'S JOURNEY IN ACCESSING SERVICES

Family A:

Parents of a 6 year old male (1st grade) diagnosed with a Mood Dysregulation Disorder and ADHD.

- There were too many tunnels to travel to get help. No light at the end of any tunnels.
- No one giving family guidance. Just "boys will be boys".
- No one is listening.
- Feelings of isolation.
- When connected with a community provider it took 2-1/2 months for an appointment with a child psychiatrist.
- Family like child psychiatrist, however, the office is one hour (one-way).
- Family had to seek another child psychiatrist in the area and opted for an outpatient hospital setting to receive services.
- Family is frustrated with providers that do not talk to one another.
- Family is frustrated because school district does not seem to grasp how to serve children with mental illness.
- Family feels it should be a team effort with providers involved with the child.
- Family aggravated that community providers are not responsive to phone calls.
- Family is tired of leaving voice messages and not speaking to a "real" person.
- Family feels something needs to change now rather than later.
- Lack of services is pushing families over the edge.

Family B:

Parents of an 8 year old male (2nd grade) diagnosed with ADHD, Manic Depression and Mood Disorder.

- Family had to figure things out for themselves.
- No one volunteered any information.
- Orange County's Emotional/Behavioral Disabilities (EBD) schools are not appropriately staffed.
- Inadequate services for children in the EBD schools.
- Child was arrested from EBD school four (4) times in a school year. Child's Baker Acts were from EBD school not home.

- Unfortunate that the child had to go through Juvenile Justice in order to receive services.
- Family had to find resources to provide therapy/counseling for children.
- There is a shortage of male psychosocial rehabilitation specialists in Orange County.
- Community providers have long waiting lists.
- Family had to learn to navigate through a dysfunctional and frustrating system.

Attachment B

SYSTEM OF CARE GUIDING PRINCIPLES

Systems of care are designed to:

- Ensure availability of and access to a broad, flexible array of effective, evidence-informed, community-based services and supports for children and their families that addresses their physical, emotional, social, and educational needs, including traditional and nontraditional services as well as informal and natural supports.
- Provide individualized services in accordance with the unique potential, strengths, and needs of each child and family, guided by an individualized, "wraparound" service planning process and an individualized service plan developed in true partnership with the child and family.
- Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
- Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
- Ensure cross-system collaboration, with linkages among child-serving systems and mechanisms for system-level management, coordination, and integrated management of service delivery and costs.
- Provide care management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
- Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
- Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
- Incorporate or link with mental health promotion, prevention, and early identification and intervention to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.

- Incorporate continuous accountability mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
- Protect the rights of children and families and promote effective advocacy efforts.
- Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and services should be sensitive and responsive to these differences.

Attachment C
Family Support Model

Providing services across the lifespan of children from prenatal stage of development through early adulthood (24 years of age). This approach recognizes that individuals from preschool through young adulthood have unique needs determined by their stage of development.

Strengthening the family system that is in a reciprocal relationship with that young child, adolescent or young adult. It is important to note that from a family system's theory, when a child is experiencing difficulties in the family, that child's challenges affect the other members of the family and the overall system. Similarly, when the family is struggling with a problem, that system's problem, be it parental mental illness, alcoholism, unemployment, health problems, divorce, or financial challenges affects the child, adolescent or young adult who is dependent on that system.

Strengths perspective & empowerment are two essential features of a model that is focused on helping families and individuals to assume an active role in their own mental health treatment. Too often we approach mental health from a pathological, medically driven model that does not always recognize the positive strengths and support systems inherent in individuals and families. For children, adolescents and young adults it is important that we identify not only the 'risk' factors but that we also pay attention to and utilize the 'protective' factors in their lives. Those protective factors come in many forms such as helpful teachers, clergy in the community, recreational programs, etc. and should be taken into account as we empower our children, adolescents and adults to seek out support systems that may already be available to them.

Intergration of Service-The Bio-Psychosocial Approach implies that we are addressing the 'whole' individual when providing mental health services. The proposed model will take into account a network of providers that will make contributions to the individual's mental health, health, family functioning, school and community spheres of functioning (Leon & Armantrout, 2007).

Collaborative partnerships are important to address all aspects of the individual's problem. Because human beings are complex individuals who live within various contextual backgrounds, it is essential that a network of providers work together to address the mental health and other related challenges.

Neighborhood Based and Family-Friendly Services ensure that services are accessible to children, adolescents, young adults and their families in environments that are accessible and familiar. Part of developing strong children, adolescents and young adults is the need to also develop and work with their existing communities. It is important to have services that are available to parents and their children at hours that make sense and are more appropriate for those parents—especially working parents. Good customer service is another important feature of this model. There is nothing more disconcerting for a parent who is already distraught to face a non-friendly provider who cannot demonstrate caring and compassion at a time of great need.

Fiscal support is a vital feature of any successful model. Efforts must be made to identify permanent, ongoing streams of funding that will sustain the model's efforts. Having good outcome measures and program evaluation activities to show the model's contributions will be important ways to advocate for continued and new funding avenues.

Identification of formal & informal community based resources & good case management services will ensure that all resources are identified and are coordinated in the most effective manner to provide services to those struggling with a mental illness. Some of our communities already have some good informal and formal resources, while others lack both. It is important within the proposed model to assess our community needs and to fill the resource gaps by providing services through the network recommended.

Attachment D

Surgeon General's Report

Goal 1: Promote public awareness of children's mental health issues and reduce stigma associated with mental illness

- Promote social, emotional, and behavioral well-being as an integral part of a child's healthy development.
- Develop and/or disseminate existing guidelines on how to enhance child development, including mental health. Different sets of guidelines will need to be created for the general public, families, parents and caregivers, and professional groups.
- Identify early indicators for mental health problems.
- Integrate mental health consultations as part of children's overall general healthcare and advise healthcare providers regarding the importance of assessing mental health needs.
- Develop a national capacity to provide adequate preventive mental health services.
- Conduct a public education campaign to address the stigma associated with mental health disorders. This could be accomplished through partnerships with the media, youth, public health systems, communities, health professionals, and advocacy groups.

Goal 2: Continue to develop, disseminate, and implement scientifically-proven prevention and treatment services in the field of children's mental health

- Support basic research on child development, and use current knowledge about neurological, cognitive, social, and psychological development to design better screening, assessment, and treatment tools and develop prevention programs.
- Support research on familial, cultural, and ecological contexts to identify opportunities for promoting mental health in children and providing effective prevention, treatment, and services.
- Support research in developmental psychopathology to help clarify diagnoses and provide methodology that is sensitive, specific, and that can be used in designing and interpreting pharmacological and other clinical trials.
- Support research in basic and clinical neuroscience to provide better information and understanding of pharmacogenetics and ontogeny of drug effects on the developing brain in the short term, as well as the long-term consequences of pharmacological intervention associated with both acute and chronic exposure.

- Support research on legal/ethical and confidentiality issues associated with the treatment of children and families.
- Support research to develop and test innovative behavioral, pharmacological, and multimodal interventions.
- Increase research on proven treatments, practices, and services developed in the laboratory to assess their effectiveness in real-world settings.
- Study the nature and effectiveness of clinical practices in real-world settings.
- Assess the short and long-term outcomes of prevention and treatment efforts, including the effect of early intervention on the prognosis and course of mental illness.
- Promote research on factors that facilitate or impede the implementation and dissemination of scientifically-proven interventions.
- Support research evaluating the process and impact of promising policies and programs, including cost-effectiveness research (e.g., EPSDT, IDEA, Head Start, SCHIP [see Appendix B]).
- Evaluate the impact of organization and financing of services on access, the use of scientifically-proven prevention and treatment services, and outcomes for children and families.
- Develop and evaluate model programs that can be disseminated and sustained in the community.
- Build private and public partnerships to facilitate the dissemination and cross-fertilization of knowledge.
- Create a forum for promoting direct communication among researchers, providers, youth and families to bridge the gap between research and practice.
- Create a standing workgroup for the purpose of identifying research opportunities, discussing potential approaches, monitoring progress in the area of psychopharmacology for young children, and addressing ethical issues regarding research with children. This group should include representatives of all interested parties, such as researchers, practitioners, youth and families, industry, and federal regulatory, research, and services agencies.
- Create an oversight system to identify and approve scientifically-based prevention and treatment interventions, promote their use, and monitor their implementation.

Goal 3: Improve the assessment of and recognition of mental health needs in children

- Encourage early identification of mental health needs in existing preschool, childcare, education, health, welfare, juvenile justice, and substance abuse treatment systems.
- Create tangible tools for practitioners in these systems to help them assess children's social and emotional needs, discuss mental health issues with parents or caregivers and children, and make appropriate referrals for further assessments or interventions.
- Train all primary healthcare providers and educational personnel in ways to enhance child mental health and recognize early indicators of mental health problems in children with special healthcare needs, children of fragmented families, and children of parents with mental health and/or substance abuse disorders.
- Promote cost-effective, proactive systems of behavior support at the school level. These systems of behavior support should emphasize universal, primary prevention methods that recognize the unique differences of all children and youth, but should include selective individual student supports for those who have more intense and long-term needs.
- Increase provider understanding of children's mental healthcare needs and provide training to address the various mental health issues among children with special healthcare needs and their families.
- Increase the understanding of practitioners, policymakers, and the public of the role that untreated mental health problems play in placing children and youth at risk for entering the juvenile justice system.

Goal 4: Eliminate racial/ethnic and socioeconomic disparities in access to mental healthcare services

- Increase accessible, culturally competent, scientifically-proven services that are sensitive to youth and family strengths and needs.
- Increase efforts to recruit and train minority providers who represent the racial, ethnic, and cultural diversity of the country.
- Co-locate mental health services with other key systems (e.g., education, primary care, welfare, juvenile justice, substance abuse treatment) to improve access, especially in remote or rural communities.
- Strengthen the resource capacity of schools to serve as a key link to a comprehensive, seamless system of school- and community-based identification,

assessment and treatment services to meet the needs of youth and their families where they are.

- Encourage the development and integration of alternative, testable approaches to mental healthcare that engage families in prevention and intervention strategies (e.g., pastoral counseling).
- Develop policies for uninsured children across diverse populations and geographic areas to address the problem of disparities in mental health access.
- Develop and support mental health programs designed to divert youth with mental health problems from the juvenile justice system.
- Increase research on diagnosis, prevention, treatment, and service delivery issues to address disparities in access to mental healthcare services, especially among different racial, ethnic, gender, sexual orientation, and socioeconomic groups.

Goal 5: Improve the infrastructure for children's mental health services, including support for scientifically-proven interventions across professions

- Encourage the health system to respond to mental health prevention and treatment service needs through universal, comprehensive, and continuous health coverage.
- Review both the incentives and disincentives for healthcare providers to assess children's mental health needs, including preventive interventions, screening, and referral.
- Provide the infrastructure for cost-effective, cross-system collaboration and integrated care, including support to healthcare providers for identification, treatment coordination, and/or referral to specialty services; and the development of integrated community networks to increase appropriate referral opportunities.
- Provide incentives for scientifically-proven and cost-effective prevention and treatment interventions that are organized to support families, and that consider children and their caregivers as a basic unit (e.g., family therapy, home-based treatment, intensive case management).
- Create incentives and support for agencies, programs and individual practitioners to develop and utilize science-based strategies and interventions in community settings.
- Determine which policies and programs for children are most cost-effective and improve access to quality care, especially among the uninsured.

Goal 6: Increase access to and coordination of quality mental healthcare services

- Develop a common language to describe children's mental health, emphasizing adaptive functioning and taking into account ecological, cultural, and familial context. A common language is important to facilitate service delivery across systems.
- Develop a universal measurement system across all major service sectors that is age-appropriate, culturally-competent, and gender sensitive to (i) identify children, including those with special healthcare needs, who may need mental health services; (ii) track child progress during treatment; and (iii) measure treatment outcomes for individual patients.
- Modify definitions and evaluation procedures used by education systems to identify and serve children and youth who have mental health needs. These definitions and procedures should facilitate access to, not exclusion from, essential services.
- Provide access to services in places where youth and families congregate (e.g., schools, recreation centers, churches, and others).
- Support the development of coordinated responses by emergency medical providers (e.g., paramedics, emergency room personnel) and community mental health service providers to expedite appropriate treatment and/or referral for children presenting with emergency and traumatic episodes in hospital emergency rooms.
- Address issues of confidentiality in ways that respect a family's right to privacy, but encourage the coordination and collaboration among providers in different systems.
- Encourage family organizations to help family members access information on enhancing children's mental health and the availability of effective treatments for mental illness so that they can make fully-informed decisions about interventions offered.
- Include youth in treatment planning by offering them direct information, in developmentally appropriate ways, about treatment options. As much as possible, allow youth to make decisions and choices about preferred intervention strategies.
- Use family advocates, such as family members with prior experience, to assist families in interacting effectively with complicated service systems such as healthcare, education, juvenile justice, child welfare, and substance abuse treatment.
- Provide a mechanism for input from youth and families in setting a national mental health agenda and in assessing policies and programs to promote mental health services delivery.

Goal 7: Train frontline providers to recognize and manage mental healthcare issues, and educate mental health providers about scientifically-proven prevention and treatment services

- Engage professional organizations in educating new frontline providers in various systems (e.g., teachers, physicians, nurses, hospital emergency personnel, daycare providers, probation officers, and other child healthcare providers) in child development; equip them with skills to address and enhance children's mental health; and train them to recognize early symptoms of emotional or behavioral problems for proactive intervention. Such training must focus on developmental and cultural differences in cognitive, social, emotional, and behavioral functioning, and understanding these issues in familial and ecological context.
- Facilitate training of new providers by building knowledge of child development into the existing curricula of professional programs and encouraging on-going training opportunities across disciplines to facilitate the development of effective partnerships.
- Develop and evaluate multidisciplinary programs for healthcare professionals that focus on child and family mental health.
- Create training support for professionals, paraprofessionals, and family advocates to keep abreast of new developments in the field of children's mental health.
- Address the shortage of well-trained child mental health specialists, particularly minority individuals, by encouraging active recruitment and the provision of incentive programs by professional organizations, federal programs, and federal legislation, and consider the development of training programs for mid-level providers in mental health to address inadequate capacity.
- Encourage professional boards for mental health specialists (e.g., psychiatry, psychology, social work, and nursing) to require training in: evidence-based prevention and treatment interventions; outcome-based quality assurance; competency-based assessment and diagnostic skills; principles of culturally-competent care; and engaging youth and families as partners in assessment, intervention, and outcome monitoring.
- Provide mechanisms to monitor and evaluate efforts to train new professionals, retrain existing professionals, and examine the effectiveness of these training efforts.

Goal 8: Monitor the access to and coordination of quality mental healthcare services

- Establish formal partnerships among federal research, regulatory, and service agencies, professional associations and families and caregivers to facilitate the transfer of knowledge among research, practice, and policy related to children's mental health.
- Encourage behavioral healthcare industry and service agencies to develop and use broad-based outcome and process measures to ensure accountability. These measures should be relevant and meaningful, such as symptom severity, adaptive functioning, family satisfaction, and societal/economic costs and benefits in terms of involvement in systems such as special education, welfare, and juvenile justice.
- Develop national quality improvement protocols that emphasize the use of scientifically-proven practices and evaluate the effectiveness of service systems.
- Encourage providers to inform consumers about evidence for and against the effectiveness of proposed treatments and services.
- Make available information on effective prevention and treatment interventions through federal partners, professional organizations, family organizations, and private foundations. In addition, provide information that will allow practitioners to evaluate the worth of promising interventions.
- Encourage industry and service agencies to develop a variety of mechanisms for consumers to communicate their experiences and concerns to funding agencies and purchasers of healthcare plans (i.e., federal, state and local governments and private employers).
- Monitor efforts to coordinate services and reduce mental health access disparities through public health surveillance and evaluation research.

The Surgeon General's National Action Agenda on Children's Mental Health. Olin SCHoagwood K, . Curr Psychiatry Rep. 2002 Apr; 4(2):101-7.

Attachment E

Payer sources and services for the 14-24 population

The 14-24 year old population is incredibly influenced by peers, social media and popular culture, therefore are very concerned about stigma of mental health services. Often, they want service that is quick and convenient. Many are navigating through significant life changes/happening often for the first time (high-school graduation, college, end of first loves, independence, sex, gender roles and stereotypes, sexual orientation, suicidal thoughts or ideation of self or friends, drug use by self or friends, driving, living with a roommate, transition from parent/child role with parents to a less dependent roll, first jobs, workplace politics and etiquette, first experience with their own money and often times their first bill/expenses).

As with the mental health system as a whole, there are multiple services in place for the 14-24 year old population. The actual services available most often are dependent upon the ability to obtain coverage (private insurance, Medicaid, Tricare, SAMH). For those individuals with a method of payment, the actual services vary greatly based on the type insurance plan in place for the individual in need. For some, private pay is also an option.

For those with Medicaid, there is more parity in coverage with medical services than those in the private pay system. Although there are multiple different payers through Medicaid (reducing to 7 for Orange County in August, 2014) all with different pre-authorization requirements, the basic coverage is similar across the entire system based on the Community Mental Health Handbook. The spectrum of services include outpatient therapy, psychiatric services and inpatient treatment. The managed care payers that are a part of the Medicaid network are able to authorize services based on medical necessity, but are limited to the types of services covered by the Medicaid handbook and their annual limits. Outside of the Community Mental Health Handbook, Medicaid services are available that include Statewide Inpatient Psychiatric Program (SIPP), Targeted Case Management (TCM), Comprehensive Behavioral Health Assessment (CBHA), and Specialized Therapeutic Foster Care (STFC). These services are more restrictive on their ability to be accessed from a referral/eligibility perspective. Other than individuals on SSI and those that have aged out of foster care, Medicaid coverage ends at 21 years of age.

The DCF Substance Abuse Mental Health office dollars are now managed through the Managing Entity (CARES). This is the "safety net program." Mental Health services are covered (Outpatient and Acute Care/Inpatient) for those that are uninsured (sliding fee scale). At this point in time, CARES has not been afforded the flexibility from DCF to design and/or contract for local, collaborative, innovative and individual centered services. Private insurance carriers have very different covered services based on the individual plans. Although parity passed at the Federal level, for the most part the level and scope of services, as well as the length of time service provision is allowed is much more restricted than Medicaid. This is particularly true of inpatient mental health services.

Tricare is available for individuals of military families. The mental health services that are available are middle of the road between Medicaid and private pay but include telehealth, which increases access to care.

For older children and young adults still in Orange County Public Schools, there are mental health services available. SEDNET 7A coordinates the provision of school-based mental health services to Orange County Public Schools. OCPS has Cooperative Agreements with 11 local community agencies that provide a variety of services to students who are in need of emotional or behavioral support.

Services are typically funded through Medicaid, Family Services Planning Team (FSPT), private insurance, or by other funding streams available to the agencies. The model for service delivery is for the agency staff to provide services both at school and at home to the child. Services provided at school will take place during non-core academic time. Services offered include counseling, case management, and mentoring.

For this population that is involved in the child welfare system, there is a coordinated approach to mental health services. Collaborative efforts are made with the Medicaid Specialty plan for foster care/former foster care youth and young adults (covered through age 26). The local Lead Agency, Community Based Care of Central Florida (CBCCFL) has systems in place to coordinate services with area providers. They also have some supplemental funds (100/800 dollars) that can enhance services not covered by Medicaid for mental health diagnosed clients. While services are more available in this system, they can still be disjointed due to the multiple players (Guardian ad Litems, Department of Children and Families, courts, foster parents, relatives, group Homes, and Targeted Case Managers) as well as restrictions by Medicaid as it relates to allowable services.

Older children and young adults can often have involvement in multiple systems beyond mental health which can include Agency for Persons with Disabilities (APD), Department of Juvenile Justice (DJJ), and the adult criminal system. It is also common to have co-occurring issues such as substance abuse, domestic violence involvement, and/or medical conditions. This can further complicate service delivery and availability (for example, if an individual is in DJJ, Medicaid services cannot be provided that is needed for mental health treatment). For those involved in multiple systems, there is often a delay in obtaining services while it is decided who is the primary "owner" of the client (payer of services). Orange County does have the Mental Health Court that helps to divert individuals from the court system that are in need of mental health services.

Dependent on the provider, there are a variety of evidence based care models in place as well as trauma informed care services. There is an increased level of attention in these areas as funders are beginning to require such practices and the movement is towards paying for outcomes versus a fee-based system.

For the young adults at the end of this age group, accessing services is often extremely difficult. Once they are over 21, and on their own they often find themselves without any insurance coverage. It is normal for these individuals to be in school, unemployed/underemployed and not able to afford or become eligible for coverage. Mental Health resources, particularly on the lower end of the service spectrum (outpatient) are not available. Once an individual reaches the stage of more severe needs (baker act, inpatient care) there can be more access to care through CARES and emergency room services. The Affordable Care Act may help some of this population obtain coverage as it rolls out, however its affordability may still be a factor.

While all of these services are available in some form, it is important to note that there is a shortage of psychiatrists in Florida. Many general practitioners are diagnosing mental health disorders and are prescribing medication to treat. The amount of licensed therapists having training in trauma informed care and/or evidence based practices is not to the level of need in Orange County (nor is it catalogued for individuals needing services to know how to access). There are also limited numbers of bilingual practitioners for our culturally diverse community. Additionally, services are not equally available in all areas of the County.

There is a very strong foundation in place. Access to these services is one of the main factors identified by the Systems Design Committee. Telehealth addresses this issue in many ways. The availability of doctors and clinicians expands greatly, as well as access to bilingual practitioners. It reduces access issues due to transportation, child care, etc. It also addresses the lack of services located in different geographic areas throughout Orange County. While not a "fix all" solution, it reduces the gaps significantly. Currently, Telehealth is not a covered service in Florida with the exception of a few Medicaid plans and private pay. Legislation is before Committees in Tallahassee to address, and it looks hopeful a resolution will come in this session. This will apply to Medicaid as well as private insurance.

The covered services in all plans need to be enhanced to include more family/individual-centered codes. The ability to be flexible and develop a treatment plan that truly identifies the needs of the individual from all aspects (and not based on what is a "reimbursable" service) is critical in the system redesign. The new Medicaid plans that will be in place by August, 2014 appear to have been given some of this flexibility. This will ease the ability to implement evidence based practices as they were intended. The movement is to also be paid for outcomes. The County may be able to negotiate a pilot with this in mind. This may ultimately lead to change in the Medicaid Handbook.

The Managing Entity (CARES) needs to be given the flexibility similar to that of the Child Welfare Lead Agency. Each community has different needs to design services and systems that enhance the mental health outcomes locally. To enhance services to older children and young adult services, the following is suggested: family therapy, with special training around working with families with teens; individual therapy with focus on working with teens and young adults; Easier access to psychiatric care (especially outpatient); Additional psycho-education; specialized training for service providers in working with this age group; domestic violence training that is specific to this age group; and more youth involvement in deciding the best setting for and type of services to address challenges.

We are missing a multisystemic approach. It is understood that there is a treatment modality called "mutisystemic therapy" that deals with specific youth in this age group with DJJ involvement. What is missing is the bigger step of comprehensively including all funding systems in Orange County that touch this population and their families.

This includes County Government, the Agency for Healthcare Administration, The Florida Department of Children and Families, the Agency for Persons with Disabilities, the Managing Entity Central Florida Cares, Community Based Care of Central Florida, the Florida Department of Juvenile Justice, the Orange County Sheriff, Orange County Public School System, Private Insurance, and Grant giving bodies at a minimum. With a fully collaborative approach, treatment can be designed with the older child/young adult at the center of the discussion to wrap them and their family with the age appropriate, evidence based, outcome driven services. These services need to be provided by individuals with appropriate training and specialties as described above.

Attachment F

Neighborhood Center Locations

Note: Lunch for seniors is not served at all of the Neighborhood Centers for Families locations. At this time, senior lunch is only served at the Apopka/Zellwood and Taft Neighborhood Centers for Families locations.

Please contact the Neighborhood Center for Families that is near you to inquire about service that may be offered at that location. The following Neighborhood Centers for Families are available to residents in 13 communities throughout Orange County:

- **Apopka/Zellwood**

6565 Willow Street
Zellwood, Florida 32798
(407)254-9430

- **Bithlo/Christmas**

18510 Madison Avenue
Orlando, Florida 32820
(407) 254-9400

- **Eatonville**

323 East Kennedy Blvd., Suite D
Eatonville, Florida 32751
(407) 629-5655
(Co-located at the Excellence without Cause Community Computer Lab)

- **Englewood**

6000 Stonewall Jackson Road
Orlando, Florida 32807
(407) 736-1040
(Located between the Englewood Elementary and Jackson Middle Schools)

- **Ivey Lane**

5151 Raleigh Street
Orlando, Florida 32811
(407) 254-9490 Ext. 1

- **Lake Weston**

5500 Milan Drive
Orlando, Florida 32810
(407) 522-2165

- **Oak Ridge**

150 Amidon Lane
Orlando, Florida 32809
(407) 850-5101
(Co-located at Walker Middle School)

- **Pine Hills**

2000 Beecher Street
Orlando, Florida 32808
(407) 294-3519
(Co-located at Mollie Ray Elementary School)

- **Taft**

9500 South Orange Avenue
Orlando, Florida 32824
(407) 850-9700
(Co-located near Orange County Head Start)

- **Tangelo Park**

5115 Anzio Street
Orlando, Florida 32819
(407) 226-1714
(Co-located at Tangelo Park Elementary School)

- **Union Park**

9839 East Colonial Drive
Orlando, Florida 32817
(407) 207-1684

- **West Orange**

303 W. Crown Point Road
Winter Garden, Florida 34787
(407) 905-5100

- **Winter Park**

901 West Webster Avenue
Winter Park, Florida 32789
(407) 622-2911
(Co-located at Winter Park Vo-Tech)

Attachment G

Mentoring – An Essential Source for Promoting Positive Youth Development

It is without a doubt that parents desire to have children that will grow up healthy, happy, and productive. They aspire to have their children possess the skills that will contribute to their own well-being and, as well as the well-being of their families, and communities. According to Theokas & Lerner (2006) substantial interaction with caring, capable, and committed adults who are invested in the lives of young people are the most important developmental asset associated with "Positive Youth Development" because the relationship can decrease low level problems and risky behaviors such as substance use or bullying, (Theokas & Lerner, 2006; Larson, 2006). This aligns with the central goal of a system of care which serves youth more effectively in their communities allowing them to maintain their relationships with families, schools, and neighbors. Community-based treatment and supports should available and provided to the child/youth and family in the home to enable the youth to stay at home. These include an array of individualized services, such as respite, mobile crisis services, crisis shelter care, intensive home-based services, skill building, and mentoring. It is important for children/youth and families to have access to a broad array of these home and community-based supports.

The Positive Youth Development (PYD) perspective integrates two key ideas. First, the belief that all young people possess strengths and second that youth development is promoted when youth strengths are aligned with the strengths, or developmental assets for healthy development present in their ecologies (Benson, Scales, Hamilton, & Sesma, 2006). The facets of the ecology of youth can be identified in any setting and constitute as key developmental assets promoting PYD. These include:

- The individuals in young people's lives (parents, teachers, coaches, and mentors);
- The institutions present in their community (after-school activities, libraries, or parks);
- Opportunities for youth and adults to work together in valued community activities (school boards, the chamber of commerce); and
- Access to these people and institutions (with adequate transportation, maintaining a safe setting for youth, or low financial costs).

While not discounting the importance of natural mentoring relationships, mentoring that occurs within the context of youth development programs may be particularly beneficial in the promotion of PYD (DuBois, Holloway, Valentine, & Cooper, 2002). For instance,

effective, high quality and enduring mentoring is associated with the capacity for youth to engage in high quality social relationships, to have greater academic achievement, school engagement, school adjustment, and to view their futures more positively (Rhodes, Spencer, Keller, Liang, & Noam, 2006).

In addition, PYD can also serve as a set of guidelines on how a community can support its young people so they can grow up competent and healthy and develop to their full potential.

- **Emphasis on positive outcomes:** The approach highlights positive, healthy outcomes (in contrast to reducing negative outcomes such as teen pregnancy, substance abuse, violence). Although most parents have clear ideas what positive characteristics and behaviors they would like to see in their children, there is still a lack of clarity of what exactly positive outcomes are. Since researchers only recently have focused on positive outcomes, definitions and categories of positive outcomes are still evolving. Examples of desired youth development outcomes are competence (academic, social, vocational skills), self-confidence, connectedness (healthy relationship to community, friends, family), character (integrity, moral commitment), caring and compassion.
- **Youth Voice:** It is essential to include youth as active participants in any youth development initiative. They have to be equal partners in the process.
- **Strategies aim to involve all youth**: Youth development strategies are generally aimed at all youth. The assumption is that creating supportive and enriching environments for all youth will lead to the desired positive outcomes as well as reduced negative outcomes.
- **Long-term involvement**: Youth development assumes long-term commitment. Activities and supportive relationships have to endure for a long period of time to be effective. They have to accompany young people throughout their growing up years. Youth development strategies have to embrace and ready themselves for long-term engagement.
- **Community involvement:** Youth development stresses the importance of engaging the larger social environment that influences how young people grow up and develop. This includes family and friends, but also the community they live in. Community is more than social service and youth organizations, schools, law enforcement agencies; it involves business, faith and civic groups, and private citizens who are not attached to any organization.

- **Emphasis on collaboration:** Youth development requires people from various agencies and community groups to work together. Collaboration can express itself in different forms e.g., agencies coming together to write a grant proposal to community groups forming a coalition to achieve one common goal by sharing resources and expertise.

The Many Faces of Mentoring

Mentoring involves a caring and supportive relationship between a child/youth/young adult, and a non-parental adult. Rhodes (2002, 2005) has proposed that mentoring affects children/youth/young adults through three interrelated processes: (1) by enhancing child/youth's/young adults' social relationships and emotional wellbeing, (2) by improving their cognitive skills through instruction and conversation, and (3) by promoting positive identity development through serving as role models and advocates. These processes are likely to act in concert with one another over time. Furthermore, the effectiveness of each of these three processes is likely to be governed, at least in part, by the quality and longevity of the relationships established between young people and their mentors.

Mentoring - Social and Emotional Development Stages

Mentoring relationships may promote the social and emotional well-being and development of children/youth/young adults in several ways. The relationships may provide children/youth/young adults with

- opportunities for fun and escape from daily stress,
- corrective emotional experiences that may generalize to and improve youths' other social relationships,
- assistance with emotion regulation (Rhodes, 2002, 2005).

Moreover, mentoring relationships also provide opportunities for children/youth/young adults to engage in a variety of social and recreational interactions with adults. Such activities may provide both welcome respite and enjoyable experiences for children/youth/young adults who typically must contend with disadvantages, mental health needs and difficult circumstances. Sarason & Sarason (2001) expand on recent research showing social support highlights involvement in mutually pleasurable social activities as a distinct aspect of supportive relationships that has been referred to as companionship. In contrast to other forms of social support sought out during times of distress, companionship is motivated by the desire to share in purely enjoyable interaction, such as the pleasure in sharing leisure activities, trading life stories and humorous

anecdotes, and engaging in playful spontaneous activities (Rook, 1995).

Keller (2005) emphasizes that mentoring relationships also have the potential to provide children/youth/young adults with positive experiences in social relationships, which may lead to improvements in other important relationships for some children/youth/young adults. By offering children/youth/young adults genuine care and support, mentors can challenge negative views that they may hold of themselves or of relationships with adults. Moreover, mentors can demonstrate that positive relationships with adults are possible. The mentoring relationship can thus become a corrective experience for those children/youth/young adults who may have experienced unsatisfactory relationships with their parents (Olds, Kitzman, Cole, & Robinson, 1997). This experience may then generalize, enabling children/youth/young adults to perceive their proximal relationships as more forthcoming and helpful (Coble, Gantt, & Mallinckrodt, 1996).
The hypothesized potential of positive relationships to modify children's/youths'/young adult's perceptions of other relationships is suggested by attachment theory (Bowlby, 1988; Sroufe & Fleeson, 1986).

According to attachment theory, a child seeks comfort and protection from caregivers in times of distress. A sense of security is restored when an attachment figure demonstrates a sensitive response that alleviates the distress. Over the course of numerous interactions, a child constructs cognitive representations regarding the reliability of care from an attachment figure and his or her own ability to elicit care in times of need (Bretherton, 1985). These experience-based expectations, or working models, are believed to be incorporated into the personality structure and to influence behavior in interpersonal relationships throughout and beyond childhood (Ainsworth, 1989; Bowlby, 1988). Although considered to be relatively stable over time, working models may be modified in response to changing life circumstances, particularly the opportunities to engage in different patterns of interaction presented by new relationships (Belsky & Cassidy, 1994; Bretherton, 1985).

Although changes in working models can occur at any point in development, mentoring relationships in adolescence may offer distinct opportunities for the revision of working models because of the increases in perspective taking and interpersonal understanding that occur during this time, as well as the desire to gain some autonomy from parental control and influence (Allen & Land, 1999; Cassidy & Kobak, 1988).

Belsky & Cassidy (1994) explain that children/youth/young adults who have experienced caregivers as unavailable or inconsistent and have models of relationships tinged with anxiety, anger, uncertainty, and mistrust may be less likely to see the value in turning to others in times of stress. However, mentors who are sensitive and consistent in their relationships with these children/youth/young adults may help them feel worthy of care and effective in attaining it. In turn, these children/youth/young adults may become more open to, and likely to, solicit emotional support to cope with stressful events or chronic adversity, thereby buffering the effects of a negative environment (Rutter, 1990). Furthermore, relationships with mentors that are characterized by consistent and responsive caregiving also may promote a sense of stability and predictability in children's/youth/young adults' lives. When the child/youth/young adult knows the mentor is a dependable source of protection and support if something should go wrong, the sense of security that results may allow productive exploration of the environment that leads to the development of knowledge, skills, and competence (Ainsworth, 1989; Bowlby, 1988).

In some cases, mentors may function as alternative or secondary attachment figures providing a secure base from which children/youth/young adults can make crucial social and cognitive strivings. In other cases, mentors may simply alleviate some of the relationship tensions and conflicts that arise throughout development, especially during adolescence. Mentors can offer children/youth/young adults adult perspectives, advice, and suggestions that might be ignored if they were presented by a parent (Keller, in 2005a). By serving as a sounding board and providing a model of effective adult communication, mentors may also help children/youth/young adults better understand, express, and regulate both their positive and their negative emotions (Pianta, 1999).

Role Modeling & Advocacy

When mentors serve as role models and advocates, they may contribute to youths' positive identity development. That is, mentors may help shift youth's conceptions of both their current and their future identity.

Markus and Nurius (1986) have referred to "possible selves"—individuals' ideas of what they might become, what they would like to become, and what they fear becoming. Such possibilities, which often emerge as youth observe and compare the adults they know, can inform current decisions and behavior. Indeed, many lower-income youth have limited contact with positive role models outside the immediate family and believe that their opportunities for success are restricted (Blechman, 1992).

As the mentor's positive appraisal becomes incorporated into the mentee's sense of self, it may modify the way the child/youth/young adult thinks that parents, peers, teachers, and others see him or her.

More generally, mentors help children/youth/young adults to build both social and cultural capital by facilitating their use of community resources and by opening doors to educational or occupational opportunities (Dubas & Snider, 1993; McLaughlin, 2000). Participation in such new opportunities can also facilitate identity development by providing experiences on which children/youth/young adults can draw to construct their sense of self. Indeed, Waterman (1984) has proposed that such activities provide opportunities for discovering special talents and abilities and are thus a primary source through which identity is formed. When mentors promote children's/youths'/young adults' participation in pro-social activities and settings, they expose them to socially desirable or high-achieving peer groups with whom they can then identify.

Community, School, and Career-Based Mentoring

Community-based (CBM) and school-based (SBM) one-on-one mentoring are the most common and the most studied types of formal mentoring. Multiple experimental evaluations have shown that CBM and SBM improve children's relationships with their parents (Karcher et al. 2002; Rhodes et al. 2005; Rhodes et al. 2000) and their peers (Rhodes et al. 1999; Karcher 2008; Wheeler et al. 2010). CBM appears to affect a wide range of outcomes, whereas the impact of SBM appears to be greatest on outcomes related to school (Herrera et al. 2007). Moreover, the size of these impacts for both CBM and SBM are quite modest (DuBois et al. 2002).

Career-based mentoring programs assist youth in preparing for the world of work by helping them develop the skills needed for particular career paths. Adults from the business and professional community meet individually with youth to help them plan for their future, explore college and career options, and serve as role models.

Mentors might show youth how to conduct a job search, help youth write resumes and cover letters, engage youth in mock interviews, teach youth "soft" skills, help youth set educational and career goals, or arrange internships or other work experiences.

The central goal of system of care is to serve youth more effectively in their communities and allow them to maintain their relationships with families, schools, and neighbors. Therefore, community-based treatment and supports should be provided to the child or

youth and family, often in the home, to enable the youth to stay at home. These include an array of individualized services, such as respite, mobile crisis services, crisis shelter care, intensive home-based services, skills building, and mentoring, among others rather than being driven by priorities and limited service menus of the categorical agencies (education, child welfare, juvenile justice, and other agencies), the child and family team has access to a broad array of home and community-based supports, such as home-based therapy, respite and mentoring services.

Factors that Affect Mentoring Effectiveness

Primarily the duration of the relationship and the frequency of meetings between mentor and mentee are related to the effects of mentoring. Slicker and Palmer (1993) found that youth who met with a mentor at least three times a week had lower dropout rates than youth in a control group who did not have mentors. Youth who self-select into more frequent meetings or longer duration in the mentoring program might experience better outcomes than their peers. Youth who are fully engaged in a program are also more likely to increase program effectiveness as well. To do this, programs must be relevant to youths' lives. Interventions that view youth as active social agents (Boyden and Manning 2005) who can contribute valuable insights into their situation and can have a role in implementing solutions are more likely to appeal to their target audiences. Ignoring youths' perspectives can result in misplaced interventions that overlook their needs. Secondly, the program's support for the mentor is associated with greater effectiveness of mentoring. Stronger positive effects have been observed when mentoring programs incorporate training and ongoing supervision of mentors, expectations of more frequent and longer meetings between mentors and youth, program sponsored activities to enhance the development of the mentoring relationship, parent support/involvement, and supplemental programs/services (DuBois et al. 2002; Herrera et al. 2007; Jolliffe and Farrington 2007).

Lastly, programs should reflect the needs of at-risk youth, interventions should target not only individual youth but also their families and the communities in which they live, youths' cultural diversity should be taken into account, and integrated approaches might be the most effective.