Mayor's Youth Mental Health Commission
Finance and Sustainability Committee

Final Report

Chair:
Jerry Kassab, Lakeside Behavioral Healthcare

Committee:
David Cavalleri, Health Council of East Central Florida
Duke Woodson, Attorney – Foley & Lardner
Jay Wallace, Orange County Office of Management and Budget
Jeannie Floyd, Orange County Public Schools
Marcie Dearth, IMPower
Maria Bledsoe, Central Florida Cares Health System
Muriel Jones, Federation of Families of Central Florida

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

Objectives

- The committee will develop a proposed strategy to establish financial sustainability for youth mental health in Orange County.
- The committee will provide a current estimate of resources available for youth mental health issues including prevention, early identification and treatment.
- In conjunction with the Needs Assessment Committee and the System Design Committee, the Finance and Sustainability Committee will identify the gaps in resources both financial and human to implement the proposed changes recommended by the Systems Design Committee.

Introduction

The Committee accomplished the task by:

- Outlining a finance and sustainability approach for future decision-making in Orange County.
- Proposing a structure to accomplish this new approach.
- Attaching an estimated cost to recommendations from other committees.
- Proposing long-term and short-term solutions that are in alignment with the new structure.

The present profile of youth mental health services in Orange County is characterized by a system that is fragmented and disjointed. The reasons are primarily based on the inadequate and inefficient funding structure that exists in the entire State of Florida.

Orange County and the State of Florida are some of the most poorly funded systems in the nation with Florida ranking 49th in Mental Health funding according to the Kaiser Foundation, 2013. State funding for Mental Health allocated to Orange County has remained flat for many years while the population of the county has seen a significant growth of approximately 50% since the year 2000. Additionally, our region is the 2nd lowest funded county in the state. Historically our four-county region has lacked equity in state mental health funding. Based on an economy supported primarily by local tourism, Orange County generates more sales tax revenue to the state than it gets in return. Other counties in Florida are able to ease the burden on children's mental health through use of dedicated children's funding via a local tax and a children's services council as in Miami-Dade and Hillsborough County. The dedicated funding allows the counties to implement

creative strategies in service delivery and programming to fill in the gaps in service for this population. Without a designated funding source and continued increases in population, Orange County will continue to lag behind other areas of the state in regards to youth outcomes.

Any financing approach that lacks a well-designed and planned structure will result in problems such as limited accessibility for children and families, poor treatment outcomes, duplicative services and inefficient use of resources. In Orange County currently, organizations providing services secure and spend funds that are awarded. Each funding source comes with its own set of rules and standards that further distress a system filled with regulations. Agencies are forced to limit access and availability to services and children and families suffer the consequences.

From a systemic level, services are provided without consultation or even awareness of the duplication of services that exists. In addition, many basic services to youth are provided in a primary care health setting which is only in the infancy stages of integration with mental health services. Often the primary care physicians and their staff do not have the expertise to deal with mental health issues in children/youth resulting in poor outcomes based on misdiagnosis and wrong medications being used.

The system needs to move to an approach where our organizations and services are united, their efforts are coordinated, and the services provided are exactly those required/needed by youth and families

Committee Conclusions

- **Finance and Sustainment Approach**
  - The committee recommends a long-term commitment to ensuring youth mental health shifts from a fragmented funding and service delivery structure to one that leverages funding, shares resources, aligns initiatives under one umbrella, and works toward using blended and braided funding mechanisms as much as possible. This is not an easy task and will take years to accomplish. Financial support is needed to cover the resources lacking in our community in the short term until such a time as longer term solutions can be found. A fundamental improvement in organizational structure is going to be required in order to shift the finance and sustainment approach for youth mental health in Orange County. The foundation of a new approach is to be based on principles that systems align

with and agree to. The principles would be the cornerstone of strategic planning and implementation.

- Our vision is that Orange County becomes a community that unites, coordinates and provides for the needs of youth and families. Specific finance goals include:
  - The reinvestment of savings from high-end, costly services (juvenile detention, residential treatment programs, etc.) to primary prevention and intervention initiatives.
  - Applying for federal, state and local funding with the spirit of collaboration and complete transparency instead of competition.
  - Coordinating efforts to ensure the ability to leverage local dollars and support each other's efforts instead of chasing funding.
  - Ensuring resources are directed towards evidence-based models with high-fidelity.

Short Term recommendations for the Commission

- **Establish a unified organizational structure for collective strategic planning and funding decisions.**
  - The committee proposes the establishment of a centralized authoritative body, called the Management Network hereafter referred to as the Network with supporting staff to accomplish the work. Network membership would need to include representatives from all major child serving systems (juvenile justice, health, early intervention, community mental health, child welfare, school system, etc.), as well as managed care insurance providers. The Network's primary tasks would be to define its purpose, describe its programs, set its objectives and measure its accomplishments. Additionally, the Network would maintain the oversight and responsibility as described by the System Design Committee. Maintaining standards for the community and measuring community outcomes are a critical component. For example, monitoring and reviewing quality indicators which could include the proportion of clients who drop out of outpatient services, what proportion of these services are directed to youth who are discharged from out-of-home settings, what proportion of the children and youth receiving outpatient services receive evidence-based treatment, and what proportion meet their treatment goals. Knowledge of these areas will assist Network members in their ability to make sound financial decisions for the community.

- **Establish the Network as a permanent entity supported by Orange County Government.**
    - The Network's purpose would be acknowledged as a core function of county government and would be integrated into the county's annual operating budget process. This case would not eliminate the need for either existing local funding or dedicated funding, but rather would supplement the combination of other funding sources in order to satisfy the Network's total budget requirement. This approach would, to a large extent, enable the Network to independently establish and maintain its need-based levels of activity in its various programs as designed to accomplish its purpose.
- **Maintain a focus on existing funding sources.**
    - The Network would look for opportunities to coordinate the pool-able dollars and use them for need-driven services based on their systematic assessment of priorities regarding identification, prevention, treatment, etc. As for the funding that cannot be freed from its respective use criteria or categorical requirements, the Network would integrate the use of those funds as effectively and efficiently as possible. In this case, funding is the driver or independent variable and service provision is the dependent variable, fluctuating according to the availability and use-ability of external funding sources.
- **Establish a dedicated funding source.**
    - The Network would seek a dedicated funding source through court-related revenue (filing fee, charge, or fine) which is based on an appropriate rational nexus. Possible opportunities exist within forfeitures or red light camera violations. The nature of the additional (dedicated) funding would allow the County to augment the existing funding sources mentioned above. In this case, the dedicated funding source would be a relatively reliable source of local (versus external) funding. This would enable the Network to independently maintain some reliable level of service provision, without being totally subject to the fluctuations and limitations of external funding sources.

Long-term recommendations for the Network

- Expand and diversify the types of services available to children, youth and families in our community:
  - Florida Medicaid – In comparison to the rest of the nation, the Florida Medicaid plan is limited in the diversity of services funded. This has resulted in children, youth and families having to utilize the services that exist, instead of the services that they need for success. (See Needs Committee report). The Network would continue the work of expanding the types of services available through a strategic marketing/outreach plan to the Managed Care Organizations, (MCO's) which at this time appears to be the most viable option. It should be noted, however, that many areas of the nation have shifted their funding strategy through use of waivers and carve-outs. An example is provided in ***Attachment B***, and may be considered a possibility in the future.
  - Private Insurance Companies – Private companies rarely offer services beyond traditional mental health services such as outpatient therapy and psychiatric medication management resulting in over-utilization of high-end, costly services. The same strategy for educating private companies and supporting an expansion of the service array is key. The Network will include representation from managed care companies.
- The Network will unite and coordinate services in the child serving systems so they complement each other and work in conjunction with each other. Most of the aforementioned systems make decisions at a state level with little input for the actualities of the local level. The Network would need to work collectively to ensure local input is received and valued.
- Establish braided funding models in our community. The term braiding is used because multiple funding streams are initially separate, brought together to pay for more than any one stream can support, and then carefully pulled back apart to report to funders on how the money was spent. Most federal funding streams require careful tracking of staff time, with requirements for allocation of personnel hours and other expenses to specific federal streams. There are opportunities for funds to be braided between child welfare, juvenile justice, etc., to support larger service initiatives such as mobile crisis, for example.
- Work towards blended funding models amongst large systems in our community Blended funding is a type of financial mechanism where dollars for children's

mental health is placed into one large pool of money and distributed throughout the community as deemed necessary. No one agency or organization would "own" the monies, instead seeing it as a purely collaborative and non-competitive effort. Such a system would be difficult to develop and maintain without changes to policy at a state level. When it comes to developing a blended approach towards funding, it is critical to have high level members of local organizations on board early. Without full buy in from the leaders of mental health agencies, the process would be doomed to fail. Wraparound Milwaukee, for example, uses a blended funding pool; combining funds from four systems: child welfare, juvenile justice, Medicaid, and behavioral health. This model has allowed them to have a diverse and broad array of services for the community, including mobile crisis, wraparound, peer support, mentoring and respite. A blended funding model has the advantage of allowing the systems to share costs and risks and maximizes the use of resources.

- Establish a uniform data collection and tracking mechanism.
    - The appropriate system would greatly assist efforts in determining the efficacy of programs for internal and external reporting and future funding purposes. Accountability is a key component for many stakeholders seeking to learn if their investment has yielded positive returns, or if the program should be modified to better suit the needs of those it helps. Disparate data collection and tracking mechanisms create the potential of undermining well-intentioned efforts that make it difficult to ascertain whether Program A is productive and cost effective or if Program B offers a better return on investment.

Cost Projections for Committee recommendations with proposed funding mechanisms

The Finance and Sustainability Committee created a financing matrix that reflects all of the recommendations of other committees and provides an estimated budget when accurate and reflective projections could be established ***(See Attachment A).***

Children's Mental Health Expenditures in Orange County

****Information provided by the University of South Florida for Wraparound Orange. This can be utilized as a starting point to establishing baseline financial information for Orange County.**

Financial Map for Mental Health/Substance Abuse Services for Children Ages 5 through 17 in Orange County

Service Type	Medicaid		GR (SAMHIS)
	Medicaid *N* = 13,045	Child Welfare PMHP *N* = 874	*N* = 4,452
Prevention/Outreach MH	--	--	$1,201.59
Prevention/Outreach SA	--	--	$2,950.54
Screening/Assessment MH[1]	$1,089,885.17	$193,887.96	$40,955.73
Screening/Assessment SA[2]	$8,530.00	--	$90,108.31
Med Evaluation/Management	$454,972.43	$1,643.17	$2,028,194.06
Inpatient Acute	$506,128.30	$47,385.54	--
SIPPs[3]	$2,329,855.36	$619,328.64	$72,069.00
Residential Care	--	--	$85,959.01
Substance Abuse Detox	--	--	$150,922.81
Therapeutic Group Care	--	--	$64,446.08
Specialized TFC	$217,473.60	$691,523.80	$159,685.98
Day Treatment MH	$49,350.65	--	--
Day Treatment SA	--	--	--
Hospital Outpatient	$104,267.26	$0.85	--
Respite	--	--	$166.92
Crisis Stabilization/ER MH	$409,665.65	$50,469.32	$341,202.76
Crisis Stabilization/ER SA	--	--	--
Outpatient MH[4]	$5,426,875.89	$760,261.57	$130,030.19
Outpatient Substance Abuse	$9,215.00	--	$82,183.28
Targeted Case Management	$488,826.41	$40,602.80	$473,953.00
Case Management	$103,868.71	--	--
BHOS CW & JJ	$612,410.00	--	--

[1] Includes reassessments and treatment plan review.
[2] Includes reassessments and treatment plan review.
[3] SIPP expenditures are recorded in Medicaid institutional claims files; thus, the portion of SIPP expenditures paid by the CW-PMHP was calculated by taking 21% of the total cost. 21% is the statewide proportion of youth in SIPP who are in state custody.
[4] Includes domestic violence counseling.

Service Type	Medicaid		GR (SAMHIS)
	Medicaid *N* = 13,045	Child Welfare PMHP *N* = 874	*N* = 4,452
Community-based Supports[5]	$790,809.94	$328.32	$1,363,996.28
Peer Services	--	--	--
EBPs	--	--	--
Psychotropic Meds	$6,267,883.08	$529,788.86	$1,227,267.60
Consultation/Education	--	--	--
Behavioral Supports	$249,849.15	$6,349.72	--
Discretionary[6]	--	--	$17,700.00
Unclassified	--	--	--
Total	**$19,119,866.60**	**$2,941,570.55**	**$6,332,993.14**

A Cautionary Statement Regarding the Financial Data

The dollar amount listed has several limitations which should be considered:

- The number of youth served may not be an unduplicated number, meaning it is very possible that youth have interfaced with multiple systems, thereby lowering the number of actual youth served and inflating expenditures.
- The data provided does not include private funding, which will likely increase the dollar amount spent and may re-introduce the possibility of duplicated youth being served; (3) there was no outcome data attached to the financial data, making it difficult to determine the efficacy of the dollars spent.
- In some instances the dollar amounts cannot be separated into specific funding categories.
- Some of the funding was likely used for psychological testing not related to mental health issues, such as intellectual testing.
- It is unclear how much of the total dollar amount was expended in treatment versus assessment or room and board.
- It is difficult to ascertain how the funding is tracked within each stream.

Cost estimates are provided only for those items where the amount is known or estimated with certainty.

[5] Includes supports such as TBOS, ITOS, and tutoring/mentoring.
[6] Includes $ for arts/hobbies, youth recreation and social activities, clothing, etc.

Attachment A: Youth Mental Health Commission Financing Overview

"Expanding Systems of Care"

Immediate – Year 1 (2014)

Recommendations	Action	Preliminary $ Estimates
• Wraparound Orange Expansion	Expands 3 teams to serve 13-14yrs	Currently grant funded (State-3years) New
• Crisis Intervention Team Youth Training	Training for Law Enforcement	Currently grant funded (State-3years) New
• Domestic Violence Tool	Educate Physicians to complete HITS – screening tool	Currently in partnership with Florida Hosp and Harbor House
• Merge with DV/Children's Summit	Aligns community initiatives	No cost
• Implementation Team/Management Network	Engage stakeholders and managed care companies, expand system of care core values, explore recurring revenue and finance strategies	$200,000 – 3 FTE's (Sr Program Manager, Admin, QA) *
• Centralized Intake	Phone/response for family/youth crisis support and behavioral health navigation	Cost TBD *
• Public Awareness Campaign	PSA's, messaging to reduce stigma	WUCF Commitment to PSA, grass roots – NAMI
• Management Information System	Coordinated intake and referral for the community	$150,000 to build, $65,000 annually to maintain*
• Mobile Crisis Team	24/7 crisis response	$900,000*

**Denotes that financing mechanism not established.*

• Implement the Infant Mental Health Plan	Implementation and Financing of the plan	Cost TBD*
• Implement the Transition Age Youth Plan	Implementation and Financing of the plan	Cost TBD*
• Implement the Impact of Violence Plan	Implementation and Financing of the plan	Cost TBD*

2014 Legislation	• Children's CAT TEAM – serves youth with severe and persistent mental illness	$750,000 State Revenue
	• Mental Health First Aid	$30,000 State Revenue

Year 2 (2015)

Recommendations	Action	Preliminary $ Estimates
• Continuation of Year 1 activities	Expand System of Care, continue leveraging, community integration and financing strategies.	$Cost TBD*
• Common Assessment	Implement an evidenced based tool to capture outcomes at the individual/systems level (CANS Child and Adolescent Needs and Strengths tool)	Cost TBD *
• Wraparound Orange Expansion	Add teams to serve 0-5yr and 18-24yr	$90,000/team – Number of teams TBD*
• Community Training	Expand the use of evidenced based clinical interventions in the school/community	$200,000*

**Denotes that financing mechanism not established.*

• Credentialing of Professionals	Establish and Implement Credentialing Standards for agencies to be part of the Coordinated Network	No cost
• Research and Evaluation	Develop and Implement a research and monitoring system to measure community change	$200,000*

Year 3 (2016)

Recommendations	Action	Preliminary $ Estimates
• Continuation of Year 2 activities →		Cost TBD*
• Expand System of Care	Continue to impact community resources with the values of family-driven, youth-guided and culturally and linguistically competent	No additional Cost
• Evaluate yr1/yr 2 Data	Continued monitoring of community indicators and use of a continuous quality improvement model	No additional Cost
• Revisit legislative funding/grant funding	Provide system outcomes to justify renewal and/or new funding opportunities	No additional Cost

**Denotes that financing mechanism not established.*

Year 4/5 (2017-2018)

Recommendations	Action	Preliminary $ Estimates
• **Continue/Maintain Prior Year Strategies** • **Continued Accountability** • **Continued Monitoring of Outcomes** • **Reassessment of Community Needs**		**Cost TBD***

****Note – Costs should decrease over time as the community finds alternative funding sources to cover expenses*

Denotes that financing mechanism not established.

Attachment B

Example of use of a Waiver by Wraparound Milwaukee to fund children's mental health services.

Integrating Systems of Care

Because youth frequently have multiple, overlapping risk factors, interventions often require the coordination of more than one agency or institution. Failure to coordinate care can lead to some youth falling through the cracks or not receiving all the supports they need. Funding streams that can only support particular types of services and agencies with different foci complicate this issue further. However, there are some states that have seen the importance in community-based mental health prevention and intervention services. For example, Montana's Department of Public Health and Human Services submitted a 1915(i) Home and Community Based Service (HCBS) State Plan amendment to the Centers for Medicare and Medicaid Services (CMS) to establish a 1915(i) HCBS Statewide Plan program of Medicaid funded home and community services for youth who have serious emotional disturbance. The program's purpose is to provide mental health services to qualifying youth in the community setting.
http://www.dphhs.mt.gov/mentalhealth/children/i-home/PolicyManual.pdf

Purpose

The purpose of the 1915(i) HCBS State Plan program is to provide mental health services to qualifying youth in the community setting. Services will be provided through a wraparound service model that includes the youth and family and will be structured to provide the supports needed to maintain youth safely in their home and community.
The UR contractor's regional care coordinator (RCC) will develop the initial and annual service plan in collaboration with the youth, the parent(s)/legal representative of the youth, appropriate health care professionals, and others who treat or have knowledge of the mental health and related needs of the youth. The regional manager will revise the service plan based on input from family teams via the wraparound facilitator, provide program oversight, and prior authorize all 1915(i) HCBS State Plan program services. Families choose the providers they want for their family wraparound team.
Regional Manager oversight may include observation of at least one meeting in each of the four phases of wraparound to ensure the high fidelity wraparound facilitator is maintaining wraparound fidelity; contact with the youth/family periodically to ensure the youth and parent(s)/legal representative is in agreement with the wraparound process; completion of a desk audit of the wraparound facilitators' records; verification of wraparound facilitation training and certification process.

- **1915(i) HCBS State Plan Program Services**
  - In accordance with federal regulations, 1915(i) HCBS State Plan program services must not be provided to youth who are inpatients of a local

community hospital or a psychiatric residential treatment facility. Youth enrolled in the 1915(i) HCBS State Plan program are NOT eligible for targeted case management services or other types of case management services. The department may determine the particular services of the program to make available to an eligible youth based on, but not limited to, the following criteria:

- Need of the youth for a service generally and specifically;
  (b) Suitability of a service for the circumstances and treatment of the youth;
- Availability of a specific service through the program and any ancillary service necessary to meet the needs of the youth;
- Availability otherwise of alternative public and private resources and services to meet the need of the youth for the service;
- Risk of significant harm for the youth if not in receipt of the service;
- Likelihood of placement into a more restrictive setting if not in receipt of the service;
- Financial costs for and other impacts on the program arising out of the delivery of the service to the youth.

- **Peer-To-Peer Services**
  - Peer-to-Peer services offer and promote support to the youth or to the parent/legal representative of the youth. The services are geared toward promoting self-empowerment, enhancing community living skills and developing natural supports. These services may include:
    - Supporting the youth or the parent(s) to make informed independent choices in order to develop a network for information and support from others;
    - Coaching the youth or the parent(s) in developing systems advocacy skills in order to take a proactive role in the treatment of the youth; and
    - Assisting the youth or the parent(s) in developing supports including formal and informal community supports.

- **Non-Medical Transportation**
  - Non-Medical Transportation is the provision of transportation by agencies through common carrier or private vehicle for the access of the youth to and from social or other nonmedical activities that are included in the service plan. Non-Medical Transportation services are provided only after volunteer transportation services, or transportation services funded by other programs, have been exhausted. Non-Medical Transportation services must be provided by the most appropriate cost effective mode.

- **Wraparound Milwaukee**
  - It is the policy of Wraparound Milwaukee to promote quality one-to-one Mentoring services. Below are some of the programs they currently integrate in the Wraparound process with the families served.

http://county.milwaukee.gov/ImageLibrary/Groups/cntyHHS/Wraparound/2013-Policies/MentoringPolicy.pdf

- **Peer Services: Parent and Youth Support Services**
  - Parent and youth support services include developing and linking with formal and informal supports; instilling confidence; assisting in the development of goals; serving as an advocate, mentor, or facilitator for resolution of issues; and teaching skills necessary to improve coping abilities. These peers provide support, education, skills training, and advocacy in ways that are both accessible and acceptable to families and youth.

- **Other Home and Community-Based Services**
  - States have also developed service definitions for a variety of additional home and community- based services that have proven to be important for children and youth with mental health conditions to be successful in the community. This includes: mentoring, supported employment for older youth, and consultative services. These types of services may be provided through 1915(c) waivers and the 1915(i) program.

Mayor's Youth Mental Health Commission
Impact of Violence Workgroup

Final Report

Chair:
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Committee:
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Audrey Bowen, Community Advocate
Bill Tovine, Orange County Public Schools
Cathy Pope, Orange County Public Schools
Dave Joswick, New Hope for Kids
Laura Eidson-Cosgrove, Eidson Insurance
Laurie Reid, Breaking the Cycle
Larry Krantz, Orange County Sheriff's Office
Linda Outlaw, Wraparound Orange
Linda Sutherland, Orange County Healthy Start Coalition
Marie Martinez, Orlando Health
Ruth Patrick, BETA Center
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Tara Hormell, Children's Home Society
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Tom Greenman, Lakeside Behavioral Healthcare

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Heather Thomas, Orange County Mental Health & Homeless Issues Division

Objectives

- The workgroup will identify the current research on the issue of the impact of violence on the mental health and behavior of youth.
- By working with the Needs Assessment Committee, will develop and estimate the number of youth at risk.
- By working with the Systems Design Committee, will recommend strategies to reach and help youth at risk to be included in the comprehensive model.
-

Introduction

The workgroup met on three dates to address the issues surrounding children who are exposed to various types of violence and how subsequent mental health issues can be addressed and prevented. The following is a list of recommendations from the committee

Committee Conclusions

- All women who are pregnant should be screened for intimate partner violence and referred for services.
    - Research shows that children who are exposed to violence, even in utero, have significant developmental and mental health issues later in life. If fact, brain development can be significantly affected. Additionally, mothers who are abused are more likely to experience issues bonding with their newborn which can result in attachment disorders later in life. The committee recommends encouraging all hospitals and OBGYN's to screen utilizing the HITS tool and the Healthy Start screening assessment and then following up with referrals to a certified domestic abuse agency for services if the screen is positive for domestic violence.
- All children who are exposed to abuse in the home, whether witness to domestic violence or victims of child abuse, should be referred to qualified providers for post incident counseling.

- The committee's research determined that few if any children identified as victims of abuse or witnesses to abuse in the home were referred for counseling unless they came into care or the case was founded. Of those referred for counseling, few accepted services due to confusion over where to seek services, affordability and stigma.

- All children who witness abuse in the community should be referred to qualified providers for post-incident counseling.
  - The committee recognizes that many children in our community witness violence as a bystander on a regular basis. This may be in their neighborhoods or schools. The committee recommends creating an awareness and referral process where children who have witnessed a violence incident have the opportunity to seek appropriate counseling. This would require law enforcement, school officials and child welfare personnel to ensure referrals were provided to children and their families post-incident.

- All children who are bullied or engaging in bullying should have access to quality mental health counseling and understand their legal rights to end abuse.
  - The committee examined several national best practices on how to support children and their parents when bullying occurs. The committee recommends further investigation into the Colorado model for implementation. Further, the committee recommends that children have 24 hour access to qualified therapists who can counsel. The current bullying hotline only allows students to leave a message for tips.

http://www.bullyingprevention.org/index.cfm/ID/1/Home/

http://www.ed.gov/news/press-releases/us-education-secretary-highlights-best-practices-bullying-policies

- Consider a change of state statute to address bullying
  - Currently state law requires victims of bullying to meet the standard of stalking. The committee recommends review of other state laws to determine if a change in law would allow for greater accountability of bullies.

http://www2.ed.gov/rschstat/eval/bullying/state-bullying-laws/state-bullying-laws.pdf

- The community should set standards to determine the minimum qualifications and training for someone to provide therapy to a child who has experienced trauma due to violence.
    - The committee feels strongly that while master's level counseling programs prepare practitioners for basic therapy, it does not prepare them to provide therapeutic counseling to children who have been traumatized. Currently, no advanced courses in trauma treatment exist in Central Florida and most qualified therapist must go out of town or out of state to receive the training necessary. As a result, there are few qualified therapists practicing in the community.

    - The committee would further recommend that a local university be approached about expanding its post graduate therapist training to include a specialization in child trauma treatment. The training should replicate national best practice standards for child trauma therapists like those represented in the Child Traumatic Stress Network.

- Creation of a referral list of qualified providers by expertise, clients allowed, payment allowed and cost.
    - The committee found that even amongst those in the workgroup, it was difficult to determine what services were available, where therapists qualified in trauma were located and how services could be paid for. Creation of an online listing of providers who met the minimum qualification is necessary so parents can access services for their children.

- Implementation of a 24 hour hotline staffed by qualified therapists who can counsel, screen and appropriately refer families to the right mental health service.
    - Similar to the national hotline in Canada, Kids Help Phone, a 24 hour hotline staffed by therapists who can not only counsel children and their parents, but also determine the right resource for the family should be created. Too often families are given a list of providers but they are not appropriate for the needs of the family. Families may give up after calling several providers only to find that they only accept families with active DCF cases or Medicaid. The hotline could also serve to help children whose parents are not willing or able to seek therapy for them. These children can get the support they need in the short term while being appropriate referrals for help.

Resources

http://www.bullyingprevention.org/index.cfm/ID/1/Home/

http://www.ed.gov/news/press-releases/us-education-secretary-highlights-best-practices-bullying-policies

http://www2.ed.gov/rschstat/eval/bullying/state-bullying-laws/state-bullying-laws.pdf

Mayor's Youth Mental Health Commission
Public Awareness and Community Education Committee

Final Report

Chair:
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Lee Isbell, Orange County Corrections
Dick Jacobs, Center for Drug Free Living
Dr. Lauren Josephs, Visionary Vanguard Group
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Jerry Kassab, Lakeside Behavioral Healthcare
Jim Kitchens, The Kitchens Group
Liz Kitchens, The Kitchens Group
Tracy Lutz, NAMI of Greater Orlando
Therese Murphy, Marketing Consultant
Laurie Reid, Breaking the Cycle
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Heather Thomas, Orange County Mental Health & Homeless Issues Division

Objectives

- The committee will develop a communications plan that will result in the increased awareness of youth mental health issues.
- The committee will develop a survey to determine the awareness of and attitudes toward youth mental and behavioral issues.
- The committee will develop a specific communications plan and strategy to address the stigma surrounding mental health and seeking help.

Introduction

The Public Awareness and Education Committee was charged with developing recommendations intended to contribute toward reducing the stigma associated with children and families dealing with mental illness. This committee includes individuals who have shared their personal experiences with mental illness in their own family units, bringing an authentic perspective to the issue and our assignment.
It goes without saying that eliminating or reducing the stigma associated with mental illness is no small task. However, a smart, well-executed initiative designed to educate can contribute toward changing perception and behavior for the positive.

Committee Conclusions

- In general, stigma associated with mental illness and particularly with youth has been amplified in recent years by the incessant and sensationalized news coverage of major events such as Sandy Hook, teen suicides, bullying, cyber-bullying and other high-violence events.
- A new, national conversation about mental illness has been taking place laying a foundation for local community dialogue, as well as for creation of a call to action to correct misperceptions and quell fears about mental illness.
- The community needs a Call-to-Action to inspire forward movement and engagement. Thanks to momentum from this national focus, there is no need to reinvent the wheel. While our recommendations incorporate original ideas from committee members, our focus is on leveraging existing models or initiatives that seem to be making a positive difference.

- It is critical that this effort have a "collective impact" in that it must involve engagement from a variety of organizations to affect a change in reducing stigma.
- A variety of programs, organizations and services exist throughout the county, but there appears to be no centralized, coordination of resources where those in need can easily and comfortably find help.
- The many organizations dedicated to addressing youth mental illness matters remain vertical in terms of consistent information sharing or visibility about an issue that this committee believes could be helped with a shared platform or system that would open communication channels.

Key Obstacles

- People don't understand the realities of mental illness, how it can be managed and how families are left to fend for themselves.
- Media coverage of major tragedies such as Sandy Hook and the myriad of other public venue shooting incidents involving young people contribute to fanning the flames of fear and perpetuating stigma.
- Navigation – an inability to find the right open door
    - Families that need help don't know where to start.
    - If they start with the wrong door, they don't get what they need and will give up.
- Families seeking help are often presented with a "menu" of services, but those may not be the help they need.
- Funding
    - Florida is ranked 49th in the nation for mental health funding and Orange County and the Central Florida region is ranked the 2nd lowest funded in the state despite having the fourth largest child population (Kaiser Foundation, 2013).
- Public misconceptions, fears and the stigma may discourage parents and children from seeking help. For example:
    - **MYTH:** Persons with mental illnesses are dangerous.

- **FACT:** The absolute risk of violence among the mentally ill as a group is still very small and . . . only a small proportion of the violence in our society can be attributed to persons who are mentally ill (Mulvey, 1994)."
- **MYTH:** Children do not experience mental illnesses. Their actions are just products of bad parenting.
- **FACT:** A report from the President's New Freedom Commission on Mental Health showed that in any given year five to nine percent of children experience serious emotional disturbances. Just like adult mental illnesses, these are clinically diagnosable health conditions that are a product of the interaction of biological, psychological, social, and sometimes even genetic factors.
- **MYTH:** It is easy to get help because resources are available and easy to access.
- **FACT:** Parents reported over and over difficulty with navigation, getting correct information and knowing where to go. (Health Council Retrospective Study for Wraparound Orange).

Developing Strategies to Eliminate the Stigma Associated with Mental Illness

Objective

Implement a multi-level communications strategy and tactical plan that contributes toward shifting misperceptions, fears and behaviors associated with understanding mental illness to minimize stigma.

Strategy

Develop a tactical strategy that opens communication channels, raises a positive profile about managing mental illness in youth, and elevating the principle theme that mental illness can be successfully addressed and treated like other healthcare issues.

Tactical Recommendations

- Conduct public opinion survey to gauge local awareness and attitudes toward youth mental and behavioral issues.
- Develop and share key clear messaging that validates the idea that mental illness can be effectively treated and managed, and that many children and families are doing so successfully. Messaging should be coordinated and designed according to the multiple platforms and audiences to ensure relevancy.
- Identify examples of families managing successfully to validate key messages.
- Rollout initiative in public forum to raise awareness of work being done and what is needed ahead.

Specifics

- Establish Orange County Public Schools (OCPS) as top-down, point of entry in providing information/resources for services to children and families. (OCPS mission is to lead our students to success with the support and involvement of families and the community).
- Conduct school system and community audits of existing services/programs (after-school, external programs, etc.) communication products and protocols within OCPS to identify what is currently available but perhaps not widely known.
- Develop metrics: what works, what doesn't and what is appropriate audience receiving assistance. Also need to know why.
- Establish a sustainable, high-level, system-wide entry point to open channels for specialists such as National Alliance on Mental Illness (NAMI) and Federation of Families of Central Florida (FOFCFL), Mental Health Association of Central Florida who are able to offer counsel and program assistance in reaching targeted audiences.
- Establish and raise awareness of multi-platform contact point where children and families can feel safe and comfortable to call for assistance, guidance and emergency help. Options include:
  - Expand/renovate existing 2.1.1 hotline operated by Heart of Florida United Way
    - Do so with public awareness campaign to introduce updated hotline.
    - Ensure navigators can provide follow-through for those calling in – goal is to direct the caller to the right place quickly and ensure linkage is successful.

        - Ex: 2.1.1 contact for a Mobile Crisis Team
    - Create new contact platform (voice/internet/texting) all-in platform specifically for youth-related, family mental illness issues, concerns.
        - Example: (SpeakOut Hotline, which is managed by Crimeline, remains attached to "crime" contributing to perpetuating stigma. Build on same platform with independent branding).
        - Platform would serve as resource for immediate and emergency needs as well as for child/teen/parents who just seek basic help, feedback, someone to talk with, perspective about their circumstances.
- Develop a specific communications awareness campaign to address the issue of stigma surrounding mental health and seeking help.
    - Create glossary of key terms that contribute toward more appropriate language to be used in reference to mental illness.
- Implement Training and programs for first responders, educators, etc. Ex: Crisis Intervention Team Youth Training (CIT-Y), and Mobile Crisis Units.
    - Modeled after law enforcement training for management of sexual assault cases and victims and designed to diminish stigma attached to assault victims.

Public Awareness Campaign

- Develop branded and identifiable key message/theme: Youth Mental Illness Issues:
    - Manageable
    - Identifiable
    - And positive outcomes are possible in light of difficulties and fears
    - Early intervention improves outcomes
    - A public health approach is required
- Design "road show" pushing awareness campaign throughout the community:
    - Billboards, Lynx buses, etc.
    - PSAs (WUCF as a partner) and use traditional and social media options
    - Bloggers
        - A meet-up focused on the issues
- Incorporate the "real families" of youth mental illness as "storytellers":

  - Well-known and ordinary citizens to serve as "storytellers" (Committee members perhaps, and the youth and families already involved in telling their stories through Wraparound Orange).
  - Advertise the online resource "Start Your Story" website created through Wraparound Orange. http://startyourstoryhere.org./login
  - Create a "Dr. Oz" expert on youth mental illness: acquire commitment from charismatic local pediatrician and/or psychiatrist to provide sense of authority, safety and focus on attacking stigma issues.
- Create major event to announce campaign
  - Keynote speaker (potential): Pastor Rick Warren (already speaking publicly about stigma).
- Incorporate "story tellers" (this committee's volunteer members).
- Develop key messages.
- Create talking points.
- Coordinate appearances by "story tellers" within the school system and throughout the community to connect with those who may remain in the shadows due to stigma.
- Campaign would include benchmarks and measurements system to identify stickiness of message and outcomes; increased outreach and assistance by and to those in need.

Corporate Partnerships

- WUCF
- Billboard companies
- Healthcare providers
- Traditional corporate involvement (HR Departments, etc.)
  - Bright House Networks
  - Walt Disney World
  - Sea World

Conclusion

Minimizing stigma is about changing behavior, one of the hardest tasks to achieve – but not impossible. Timing is on our side as individuals and organizations demand that the issue of mental illness be addressed through awareness, accuracy and the freedom and safety of seeking treatment. A continued push to force society to see the facts beyond the chatter and white noise of knee-jerk news coverage can indeed make a difference. This is the nation's new civil rights movement and it is achievable but certainly not without a great deal of hard work, flexible strategic thinking and commitment.

**** Through Orange County and Wraparound Orange, the Youth Mental Health Commission requested the completion of a survey to establish baseline data for the values beliefs of a sample of Orange County residents. The polling was completed by the Kitchens group and can be reviewed in* ***Attachment A.***

THE KITCHENS GROUP

Attachment A – Polling Summary

Methodology

Four hundred residents of Orange County, Florida were interviewed in a sample conducted March 4-9, 2014. Interviews were conducted via the Internet using Survey Analytics' Internet Research Sample. The sample was balanced for all known demographic factors. The margin of error for this survey is a +/- 4.9%, with a 95% level of confidence.

- **Orange County residents recognize children's mental health is a serious and growing problem in our community (66%).**
- **Stigma is an obstacle to acknowledging there is a problem and in seeking help.**
- **Pervasive inaccurate beliefs (stigmas) around the issue of children's mental health are prevalent in this community.**

Eighty percent (80%) of survey respondents believe many childhood problems labeled as mental illness could be solved with better parenting and discipline. A majority, seventy-six percent (76%) believe certain behaviors exhibited by teenagers are not mental illnesses, but part of growing up. Seventy percent (70%) of respondents say violent acts are not really mental illnesses but just "mean" personality traits. More than one-third (35%) of the residents say they do not believe children even experience mental illness.

- **Parents Experience Embarrassment Over the Issue of Children's Mental Health and Don't Know Where to Seek Help**

Eighty-four percent (84%) of survey respondents say they think parents are "embarrassed" if they have a child with mental illness. Also, eighty percent (80%) of respondents say they understand how parents might feel they are to blame for their child's problems. Seventy-eight percent (78%) recognize parents could give up seeking help because they do not know where to go.

- **Parents, the school system and county and city governments are deemed responsible for addressing children's mental health issues by a strong majority of Orange County residents.**
- **A strong majority of Orange County residents support actions to address these problems, including increasing financial resources to do so.**

Attachment B – Survey Example

Area: _____Orange County, Florida_____ N=400

Introduction: We are conducting a survey of Orange County residents about issues facing this community. Your responses will be confidential and only used for compiling data about how Orange County residents feel about certain issues and policies.

1. In which of the following age groups do you fall? (1) 18 to 29 (2) 30 to 39 (3) 40 to 49 (4) 50 to 59, (5) 60 to 69, (6) 70 or older

2. Are you a (1) man or (2) woman?

3. Which of the following best describes your race or ethnicity? (1) White (2) Hispanic or Latino, (3) African American (4) something else

4. What is the zip code of your home address _____
One issue this community is starting to address is mental illness in children and teenagers.

5. How has mental illness in children and teenagers in our community changed in the past ten years? Has it become a
(1) much more serious problem
(2) somewhat more serious problem,
(3) stayed the same,
(4) a somewhat less serious problem,
(5) a much less serious problem or
(6) not sure

6. In this community, how would you compare mental illness to other problems children and teenagers face such as asthma, obesity, or childhood diabetes? Would you say it is a
(1) much more serious problem,
(2) somewhat more serious problem,
(3) somewhat less serious problem, or
(4) much less serious a problem?
(5) unsure

7. Some people say psychologists have been labeling certain bad behaviors in children as mental illness when these behaviors are just problems that could be corrected by better parenting. How accurate do you think this statement is?
(1) definitely accurate,
(2) probably accurate,
(3) probably not accurate or
(4) definitely not accurate?
(5) unsure

8. Do you believe mental illness in children and teenagers is a disease just like a physical disease such as a lung or heart disease?
(1) yes
(2) no
(3) unsure

Please tell me if you strongly agree, somewhat agree, somewhat disagree or strongly disagree with each of the following statements. **(rotate order of presentation)**

9. Children and teenagers who have a mental illness are usually violent and will try to hurt other people.

10. Sometimes people label certain behaviors in teenagers, like depression, as mental illnesses, when really it's just kids facing problems with growing up, like all teenagers face. They are not really mentally ill.

11. If I learned that one of the children in my child's school class was mentally ill, I would want that child removed from the class to protect my child.

12. If someone is mentally ill, it will show up when they are children. It is not something that naturally develops when they are teenagers or young adults.

13. Sometimes kids who commit violent acts are not mentally ill, they are just naturally mean. It is their personality.

14. A lot of childhood problems that are being labeled a mental or emotional illness could be solved with better parenting and more discipline at home.

15. I believe that parents who are trying to get help for a child with a mental illness often give up because they can't find out where to go for the help they need.

16. The reason people believe children and teenagers are more violent than they used to be is because there is more reporting of the violence in the news media.

17. If my family needed help with a child who had a mental illness, I would not know where to go or even where to start to deal with the problem.

18. Parents who believe their child has a mental illness are often too embarrassed to talk about the problems or seek the help they need.

19. I could understand how parents might feel they are to blame for a child's mental illness.

20. I do not believe children really experience mental illness. Their behavior is a result of other factors like bad parenting, poor discipline in school, or peer pressure.

21. Tragic incidents like the shooting at Sandy Hook Elementary School in Connecticut, teen suicides, bullying, cyber bullying, and other high violence crimes are widely reported and discussed by the news. Do you think this news coverage increases people's fear that mentally ill young people are usually violent?
(1) definitely,
(2) probably,
(3) probably not
(4) definitely not
(5) unsure

How responsible do you think each of the following are in dealing with children and teenagers who have mental illnesses?
(1) very responsible,
(2) somewhat responsible,
(3) not really responsible, or
(4) not responsible at all.
(5) unsure

the parents	( )
local governments	( )
the federal government	( )
the school system	( )
charities and foundations who deal with the issue,	( )
churches and other religious organizations	( )

23. In this community, do you think services to identify and treat children and teenagers with mental illnesses should
(1) be greatly increased,
(2) be somewhat increased,
(3) remain at the current level,
(4) be somewhat decreased, or
(5) be greatly decreased

24. Since children and teenagers are at school more time than anywhere else, would you support launching a school-based program to screen or test children who show signs of mental illness?
(1) strongly support,
(2) somewhat support,
(3) somewhat oppose, or
(4) strongly oppose,
(5) unsure

25. If Orange County started a program to put a mental health professional in every public school in order to identify and get treatment for children and teenagers who they identify as having a mental illness, how much more would you be willing to pay in sales taxes to fund the program –
(1) one cent,
(2) ½ cent
(3) ¼ cent or
(4) would not pay any more for this type program.

26. Florida is ranked 49th in the nation for mental health funding. Orange County is ranked as the second lowest funded county in the state even though we have the fourth largest population of children in the state of Florida. Knowing these facts, how much would you be willing to pay in sales taxes to fund the program –
(1) one cent,
(2) ½ cent
(3) ¼ cent or
(4) would not pay any more for this type program.

There are a number of actions people in Orange County are considering to address the problems of children and young adult who have a mental illness. Would you
(1) strongly support,
(2) somewhat support,
(3) somewhat oppose or
(4) strongly oppose each of the following:
(5) unsure

27. Enabling local schools to provide information about mental health issues and where to go for help and treatment.

28. Placing a mental health professional in every public school to help identify and get treatment for children and teens.

29. Establishing a mental health hotline for teens to seek help and support.

30. Providing mental health resources for youth through social media sites like Facebook and twitter.

(OTHER POSSIBLE STRATEGIES UNDER CONSIDERATION?)
We appreciate your taking the time to complete this survey, we value your input.