Legislative Budget and Finance Committee

A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY
Offices: Room 400 • Finance Building • Harrisburg • Tel: (717) 783-1600
Mailing Address: P.O. Box 8737 • Harrisburg, PA 17105-8737
Facsimile (717) 787-5487

Pennsylvania's Mental Health System for Children and Youth

June 2006

Table of Contents

Table of Contents
(Continued)

Report Summary and Recommendations

Act 2004-147 requires the LB&FC to conduct a study of various aspects of the Commonwealth's mental health system for children and youth, including the act's new consent and petition provisions. Under these provisions, a parent or legal guardian of a minor under age 18 may consent to outpatient or, on the recommendation of a physician, inpatient mental health treatment on behalf of the minor without the minor's consent.

Findings and Conclusions

A. **Nationally, about 5 percent of children have a serious emotional disturbance.** When applied to Pennsylvania, this equates to approximately 146,000 children as having a serious emotional disturbance (SED), including depression, attention-deficit/hyperactivity, anxiety disorders, conduct disorders, and eating disorders. Studies also find that about 11 percent of the juvenile population has an emotional disturbance that is significant enough to result in some type of functional impairment that severely disrupts their daily functioning in home, school, or community. Evidence suggests that mental health problems in children are increasing, with one national study reporting that the prevalence of psychosocial problems that interrupt daily functioning for children between the ages of 4 and 15 has increased from 7 percent to 14 percent from 1979 to 1996. The Substance Abuse and Mental Health Services Administration (SAMHSA) reported that, from 1986 to 1997, the number of children receiving mental health services almost doubled. Several Pennsylvania counties also reported substantial increases in the demand for children's mental health services, especially for children with autism spectrum disorders.

B. **The Commonwealth's child mental health system is fragmented and complex.** The systems used to deliver child mental health services are notoriously fragmented and complex, both at the national level and within the Commonwealth. This complexity stems, in large part, from good intentions among federal and state policymakers, with programs and agencies such as child welfare, juvenile justice, Medical Assistance, county mental health agencies, and school districts all initiating programs to meet the needs of the children they serve. The result, however, is a maze of programs that can be very difficult to navigate.

   The difficulties created by this complexity and fragmentation are widely recognized, and various efforts are currently underway to improve coordination and collaboration at both the state and local levels. These efforts include the Child and Adolescent Service System Program (CASSP), Systems of Care, the Integrated Children's Services Plan (ICSP), the Children's Behavioral Health Task

Force (CBHTF), the Autism Task Force, and the Governor's Commission for Children and Families.

C. **Both DPW and PDE report that additional efforts are needed to improve mental health services in educational settings.** The Pennsylvania Department of Education reports that partnerships between Local Education Agencies (LEAs) and behavioral health organizations are the best way to address the mental health needs of school students. These partnerships would facilitate LEAs in becoming licensed behavioral health providers and be reimbursed for the mental health services they provide in the school setting. Four intermediate units and one school district already have such arrangements. PDE and DPW also jointly sponsored a School-Based Behavioral Health Conference in early May 2006 to promote effective school-based behavioral health programs and services across the Commonwealth.

D. **Although Pennsylvania spends over $1 billion in public funds for mental health services for minors, there is no systematic approach to evaluating the effectiveness of the services provided.** In FY 2004-05, the Commonwealth spent over $1 billion in public funds for mental health services for children. Despite this level of expenditure, we found that little data exists on the outcomes achieved for services paid for by these public funds. This is of particular concern for residential treatment facilities and wraparound services (discussed below), which together account for about 50 percent of all public funds spent on mental health services for minors. To help ensure public funds are spent effectively, both the Departments of Public Welfare and Education are encouraging the use of evidence-based programs and services that have been empirically demonstrated to be effective. Recently the Office of Mental Health and Substance Abuse Services (OMHSAS) approved service descriptions for two such evidence-based interventions, which now makes them eligible for MA reimbursement. The Governor's Commission for Children and Families recommends that more of these types of programs be identified and that DPW continue to expand MA reimbursement for programs that have proven records of successful treatment.

E. **Private insurance plans provide a relatively small percentage of the funding for child mental health services.** Nationally, private insurance pays for about 22 percent of the cost of all mental health services; most (63 percent) funding comes from public funds. This is in contrast to total health expenditures, most (55 percent) of which are paid for by private insurance or other private sources. We also found that in CY 2003, Pennsylvania's Medicaid HealthChoices and Fee-For-Service programs paid about $6,900 per child for those receiving mental health services. Using data provided by two private insurance plans, we calculate these plans paid $685 and $295 per child receiving mental health services in CY 2004. These differences can be attributable to a number of factors, including employer decisions regarding covered services, private insurance dollar limits and caps on utilization, and differences in the nature of the populations covered. Another possible factor is that DPW has not had a good system for ensuring that private insurers are being billed for services that qualify for Medical Assistance (MA). Act 2005-42, passed in July 2005, requires health insurance entities to provide information on health insurance coverage and benefits to DPW. This should provide a more thorough review of the private insurance that may be recoverable to help offset the cost of MA services.

F. **After a difficult rollout in 2005, DPW's MA realignment initiative appears to be gaining acceptance.** In an effort to better integrate child mental health services, as well as capture more federal Medicaid funds, in 2005 DPW began its MA realignment effort, later renamed the Integrated Child Services Initiative. Under this initiative, DPW sought to identify those mental health services being provided with all (or primarily) state General Fund monies in program areas such as child welfare and juvenile justice and restructure them to be eligible for MA reimbursement. This is a major initiative (for example, for the two-year period FY 2005-06 through FY 2006-07, DPW budgeted up to $75.1 million in child welfare expenditures to move to MA reimbursement, with a potential for an additional $28.6 million in child welfare expenditures to be reimbursed by MA depending upon utilization by counties). The Department has made an effort over the past year to address the issues raised and provide greater opportunities to involve stakeholders in policy decisions, which appears to have alleviated many, though not all, of the concerns.

G. **Different juvenile justice programs use different screening and assessment tools, which create difficulties in monitoring children as they progress through the juvenile justice system.** Children entering a juvenile justice program are assessed to identify possible mental health or other behavioral problems in most but not all counties. The screening and assessment tools used by these programs vary considerably, which raises questions about whether the juveniles are being adequately assessed, hinders coordination between programs and counties, and makes it difficult to compare the effectiveness of various programs and approaches. Several initiatives are currently underway to standardize these tools, but legal concerns surrounding the confidentiality of information obtained during such assessments have added complications to these efforts.

H. **Wraparound services are costly, and questions exist regarding the efficiency and effectiveness of these services.** Wraparound services, also known as behavioral health rehabilitative services (BHRS), cost the Commonwealth $437 million in 2003. BHRS consists of Mobile Therapy and Behavioral Specialist Services, which are conducted by masters degree counselors, and Therapeutic Support Services (TSS). TSS workers typically have bachelor's degrees and may spend 30 or more hours a week with the child. TSS alone cost

$260 million in 2003. We heard many concerns over the qualifications and turnover of TSS workers, as well as concerns over the value of having several TSS workers in a school classroom, each watching his or her individual client. Steps have been taken in Philadelphia and elsewhere to begin controlling the cost of TSS services, but little has been done to address the broader question as to whether TSS is an effective mental health service and, if so, how many hours should be provided and under what circumstances. We also note DPW has been under a protracted legal challenge regarding concerns over the length of time required to initiate BHRS, and especially TSS, services.

I. **Act 2005-42 requires many families with "loophole" children to pay premiums and co-payments.** Pennsylvania is the only state in the nation to allow a child who meets the U.S. Social Security Administration definition of disability to be eligible for Medical Assistance regardless of parental income. These children are often referred to as "loophole," or Category PH 95, children. DPW reported 37,782 such children in Pennsylvania, costing approximately $375 million annually. To help mitigate these costs, Act 42 requires sliding scale premiums and co-payments for families with incomes greater than 200 percent of the federal poverty level. This change, however, requires the approval of the U.S. Center for Medicare and Medicaid Services (CMS). In December 2005, CMS forwarded certain questions to DPW about the initiative; as of May 2006, DPW was still developing its response to the CMS questions. Advocates and others have also raised significant questions about how this requirement would impact families and other interested parties, such as the school districts that now receive Medicaid funds for serving these children through the MA school-based "ACCESS" program.

J. **Significant gaps exist in child and adolescent mental health (MH) services.** These include:

- **Child Psychiatrists**: A shortage of child psychiatrists exists both nationally and in Pennsylvania, due largely to the lengthy training period and relatively low reimbursement rates for this specialty. As a result of the shortage, it can take up to six months for a routine appointment with a child psychiatrist. Also, certain types of evaluations must be done by a psychiatrist, which can create delays in starting services.
- **Transitional Services for Persons 18-21**: The number one gap cited by county MH/MR administrators was the lack of appropriate services for persons who "age-out" of the juvenile mental health system. These youth are often unprepared for adult life, and many of the MH services used by mature adults, such as day treatment centers, do not meet the needs of young adults.
- **Services for Juveniles With Co-Occurring Disorders**: Youth with mental health issues also often have a substance abuse problem. Programs specializing in co-occurring disorders for juveniles are scarce, and confidentiality issues

surrounding the ability of service providers to share information complicates treatment plans.

- **Educational Services in Partial Hospital Settings**: Mental health regulations require that the treatment plan for an adolescent in a partial hospital program consider the youth's education needs, but there are no specific requirements. PDE is considering establishing such requirements in the School Code, including that students in partial hospitalization programs should have access to the minimum hours of instruction required in public schools.
- **Respite Care for Families**: Many families we spoke to during this study cited the need for respite care for families, meaning an opportunity for families to have a respite from the struggles of dealing with a child with severe behavioral problems, as a major service gap. Family respite care, however, generally does not qualify for reimbursement under federal Medicaid law.
- **Outreach and Education**: As noted earlier, the child mental health system is a fragmented, complex set of programs that can take months, if not years, to learn to navigate. Not surprisingly, many families told us they had difficulty finding information about and accessing services for their children, which may be a particular problem for minority families.
- **Prevention Programs**: Medicaid does not fund prevention programs. Funds are therefore scarce for such programs, even though they can help a child from progressing to more serious mental health issues.
- **Training and Workforce Shortages**: County MH/MR administrators cite a shortage of qualified candidates and high turnover in MH positions, due in part to low pay and high stress, as serious problems. Ensuring such workers receive comprehensive, high quality training is also a widespread concern.
- **Culturally Appropriate and Gender-Sensitive Services**: Treatment services should be culturally appropriate and gender-sensitive, which can be a difficult challenge given other strains on the child mental health system.

K. **The Act 2004-147 consent and petition provisions have been used only infrequently to date, and DPW has not issued final guidance to counties or providers on the act**. Under Act 147, a parent or legal guardian of a minor under age 18 may, on the recommendation of a physician, consent to inpatient mental health treatment for their child without the minor's consent. The act also provides a process whereby the minor may then petition the court to be released from treatment. Although we are aware of only three such petitions having been filed since the effective date of the act, many questions and concerns have been raised about the process, and counties differ in how they approach the act's requirements. In January 2005, DPW distributed preliminary guidance to counties to address some of these questions, but a final document had not been issued as of May 2006. We were also informed that the act has been a useful tool for parents when negotiating the need for treatment services with their children.

L. **Initial efforts to implement the 2004 Autism Task Force report recommendations have begun**. DPW took the first steps toward implementing the recommendations of the Autism Task Force Report by appointing a Director of Autism Affairs within the Secretary's Office. In April 2006, DPW reported that it had awarded six grants, each worth $175,000, for pilot programs to develop innovative and research-based models of intervention/training and support to children and adolescents. The Department has also issued an RFP to develop a model for delivering services to individuals with autism living in rural areas of the state, another key recommendation of the report.

Recommendations

1. **The Commonwealth should develop a strategic plan and prioritize objectives for improving mental health services to children and youth.** This report, along with other reports such as the 2004 Autism Task Force Report, a March 2006 report issued by the Governor's Commission for Children and Families, and a soon-to-be-released report by the Children's Behavioral Health Task Force, identify the key issues and gaps in service delivery confronting the Commonwealth's mental health system for children. These issues now need to be prioritized and a realistic plan developed to address the top priority issues. Unfortunately, many likely "top priority" issues, such as the need for transitional programs for young adults and the lack of child psychiatrists, are either expensive or are not readily addressed by short-term state actions. On the positive side, significant efforts have already been undertaken in several important areas, such as improving coordination among county social service agencies and standardizing the screening and assessment tools used in juvenile justice programs.

   We believe a strategic plan could help to further solidify and coordinate the efforts already underway and provide unified direction for new initiatives. However, developing such a plan will be a major undertaking given the complexity of the system and the many interested parties who would need to take part in this effort, including school districts, counties, and the various related advisory and task forces associated with the system. We therefore recommend the Governor issue an Executive Order creating the position of Children's Mental Health Services Coordinator, who would report to the Secretaries of Public Welfare, Education, and Health to take the lead in developing a strategic plan for the Commonwealth's child mental health system and to house the authority and responsibility for the coordination of children's mental health services. We envision this as a permanent position, possibly administratively placed in the respective departmental policy offices with authority to coordinate across departmental policy offices, that would continue after the initial plan is developed to play a lead role in implementing the plan, revising the plan as circumstances change, and be a central point of focus to coordinate policies pertaining to mental health services for children.

Such a plan should emphasize, among other issues, steps to:

- *Address gaps in services.* Although it is unrealistic to assume that all service gaps can be fully addressed in all areas of the Commonwealth, the plan could offer steps the state, counties, and providers could take to improve the availability of child psychiatrists (e.g., by promoting telepsychiatric evaluations and services), respite care for families, transitional programs for young adults, prevention programs, services for children with co-occurring mental health and substance abuse problems, and other service needs identified in this and other reports.
- *Promote greater involvement by school districts.* Several parents cited difficulties with school districts, such as zero tolerance policies for inappropriate behavior and lack of emotional support programs, as among their greatest frustrations. One reason we are recommending the Mental Health Coordinator have a dual reporting relationship to the Secretaries of Public Welfare and Education is to promote greater involvement by the Department of Education in encouraging school districts to develop policies and services that better meet the needs of children with mental and behavioral health problems.
- *Establish effective outreach programs.* Some have suggested each county establish a parent-run outreach council as a way to provide effective outreach to parents; others have suggested a regionally based information and referral system to make it easier for children and families to access mental health services. A brochure for physicians to hand out to parents might also be a relatively low-cost, effective outreach approach.
- *Improve training for MH workers.* Although high-quality training programs are available in the Commonwealth, counties are not required by the state to send their employees to these programs, and funding constraints limit the ability to provide training to the employees of private providers.
- *Develop outcomes-based information on the effectiveness of treatment approaches.* The Commonwealth spends over $1 billion on mental health services to minors, but has little information to assess the effectiveness of these services. Recommendation 2 addresses this problem in part, but consideration should also be given to the feasibility of establishing an ongoing, results-based database that would allow researchers to compare the cost effectiveness of alternative treatment approaches.

2. **The Department of Public Welfare should take steps to further encourage evidence-based programs and services.** In particular, we recommend

the Department (or, if established, the above-recommended Children's Mental Health Services Coordinator):

- *Serve as a clearinghouse, statewide registry, and advocate for proven evidence-based programs.* We visited and were informed of a number of innovative and promising programs being tried in various areas of the Commonwealth. We recommend the Department highlight those programs that are proven to be effective and, if necessary, work to resolve any proprietary concerns so that these can be used as models by other provider agencies. By assuming a stronger leadership and technical assistance/consulting role to the counties and providers, the pertinent state agencies, especially DPW, could improve the pace with which effective programs are implemented and promote greater consistency in programs among counties.
- *Fund an evaluation study of the Commonwealth's Therapeutic Support Service program.* In CY 2003, the Commonwealth spent $260 million on TSS programs, but the effectiveness of these services has not been demonstrated. Such a study could be started at a relatively modest cost, on the order of $150,000 for a limited pilot study. The goal of the study would be to provide not only information on the overall effectiveness of TSS, but also to identify those factors (such as age, gender, severity and type of disorder, family circumstances, hours of service, and qualifications of the TSS worker) most closely associated with successful outcomes.
- *Monitor efforts to evaluate the effectiveness of residential treatment facilities (RTFs).* RTFs are also an extensive service where outcomes are largely unproven. Several efforts are currently underway, including Medicaid behavioral health managed care plans efforts, to assess the effectiveness of RTFs. If these studies find that RTFs are not effective in producing sustained positive outcomes for children, new program elements, such as efforts to better integrate the child back into his/her community setting, or alternative treatments should be explored.

3. **The Department of Public Welfare should review and, where necessary, strengthen controls to ensure the behavioral health services paid for are actually delivered.** Although DPW has various control systems in place to curb Medicaid fraud and abuse, we recommend the Department consider (1) requiring Medicaid providers submit quarterly reports to parents on the hours of wraparound services provided to their children and (2) encouraging providers to implement an automated system to document home and community-based consumer service visits if the pilot program currently being developed is shown to be successful. We realize both recommendations have associated costs, but the cost and nature of certain child mental health services, particularly TSS, may warrant these additional controls.

4. **DPW should provide guidance to providers and counties as to their responsibilities under Act 147's consent and petition provisions.** The Department licenses many of the mental health services providers and regularly provides guidance to the counties in carrying out their mental health programs. Although not specifically charged in the act with this responsibility, DPW is the state agency most directly involved in the Act 147 consent and petition process. In January 2005, DPW indicated in preliminary guidance that it would issue suggested draft language for the form referenced in the act to assist providers in this process. In late 2005, a DPW attorney reported that the Department intends to provide some guidelines, but, as of May 2006, they had not been issued. Given concerns expressed during this study regarding the rights of youth, we recommend these guidelines specifically outline the steps providers are to take to inform youth of their right to petition for release from treatment, as required by Act 147.

5. **DPW and PDE should continue to monitor implementation of the autism initiatives funded in FY 2005-06.** DPW allocated $3.0 million in FY 2005-06 to help ensure implementation of several key recommendations of the Autism Task Force Report. The Office of Autism Affairs has also employed an individual who will be conducting an official count of the number of individuals living with autism in Pennsylvania, which will provide the first real data available concerning the size on this population in the Commonwealth. Given the interest expressed in the Task Force report, we recommend the Departments continue to maintain information to assess the progress made in implementing the Autism Task Force report recommendations.

6. **The General Assembly should consider amending the Juvenile Act to address concerns about self-incrimination when using MH screening and assessment instruments**. Efforts to develop a standardized screening and assessment tool for youth entering the juvenile justice system have been hampered by legal concerns that the information juveniles provide during this process could be used against them in court proceedings. This issue has been resolved in other states through legislation that protects youth from self-incrimination.

7. **The General Assembly should consider amending existing statutes on confidentiality requirements if it is determined that these changes cannot occur through amendments to regulation**. Department of Health confidentiality regulations largely preclude sharing of information between substance abuse and mental health providers, which can hamper effective treatment plans. We recommended in a separate 2003 LB&FC report that the Department of Health make these regulatory changes, but the situation has not changed.

8. **The Department of Insurance should explore the feasibility of including evidence-based children's mental health programs in its CHIP program.** We found that the private insurers administering the Commonwealth's CHIP program do not offer as a covered service several evidence-based programs, such as Functional Family Therapy and Multisystemic Therapy, which have been demonstrated to be effective in treating child mental health problems. Such programs have, however, recently been added to the list of Medicaid reimbursable services, and such an initiative would build greater consistency in the services offered by the CHIP and Medical Assistance Behavioral Health programs.

I. Introduction

Act 2004-147 provides that a parent or legal guardian of a minor under age 18 may consent to outpatient or, on the recommendation of a physician, inpatient mental health treatment on behalf of the minor without the minor's consent. The act stipulates various provisions and conditions regarding such treatment and requires the LB&FC to prepare a report on the mental health system for children and youth in this Commonwealth. (See Appendix A)

The report is to evaluate the continuum of mental health services for children and their families and to assess the impact and effectiveness of Act 147 with regard to providing mental health treatment for children and youth. For the purposes of this report, the mental health system includes treatment services provided to children and youth who are seriously emotionally disturbed or who are at risk of becoming seriously emotionally disturbed. This report addresses other behavioral health issues only as they relate to children's mental health.

Study Objectives

The report is to include:

1. an assessment of the availability of community-based outpatient and inpatient mental health services across this Commonwealth;
2. statistical information on the number of children needing mental health services;
3. a survey of the number of petitions filed under section 1.1(b)(7) and (8) of the act, including an assessment of those petitions resulting in treatment or continued treatment, the ordered treatment period, steps taken to ensure children are informed of their appeal rights, and the impact of these petitions on the courts;
4. the timeliness with which services are delivered and the extent of those services;
5. costs for various types of mental health services for children and youth;
6. the extent to which public and private health insurance, including Medical Assistance, provides coverage for different mental health treatment and services; and
7. gaps in mental health services for children and youth.

Scope and Methodology

To conduct this review, we were involved in a number of activities, including the following:

- Reviewed applicable federal and state statutes and regulations and pertinent policy documents.
- Met with the Departments of Public Welfare, Education, Health, and Insurance; the Juvenile Court Judges' Commission; and various related advisory and task force entities.
- Administered questionnaires to county MH/MR administrators, juvenile probation officers, county children and youth administrators, and detention center administrators.
- Met with a variety of providers, county and statewide associations, organizations, and advocacy and parent groups to solicit information and opinions.
- Gathered and analyzed data from the departments and agencies on program activities, including monitoring and initiatives.
- Analyzed appropriations, allocations, and other fiscal information.
- Conducted field visits to 13 counties to acquire first-hand information from pertinent local officials.
- Contacted national organizations and other states to determine how other states administer mental health services for minors.
- Solicited comments and opinions from pertinent House and Senate committee members and other interested members.

Acknowledgements

We thank the Department of Public Welfare, especially Deputy Secretary Joan Erney and her staff, including Stan Mrozowski and Kathy Hubert. We also thank the Departments of Education, Insurance, and Health; the Commission on Crime and Delinquency; and the staff of the Juvenile Court Judges' Commission for their support and assistance. Additionally, we would like to acknowledge the assistance provided by the many county human service administrators and staff we visited or contacted either directly or through questionnaires. We also acknowledge the various stakeholders and other interested parents and persons who worked with us to identify key issues and concerns and provided data for this study, especially the County Commissioners Association; the Pennsylvania Council of Chief Juvenile Probation Officers; the Pennsylvania Community Provider Association; the Juvenile Law Center, the Disabilities Law Project; the Pennsylvania Council for Children, Youth, and Family Services; and the Pennsylvania CASSP Training and Technical

Institute. We also thank Dr. Mark Greenberg, Director of the Prevention Research Center at Penn State for his advice and consultation.

Important Note

This report was developed by Legislative Budget and Finance Committee staff. The release of this report should not be construed as an indication that the Committee or its individual members necessarily concur with the report's findings and recommendations.

Any questions or comments regarding the contents of this report should be directed to Philip R. Durgin, Executive Director, Legislative Budget and Finance Committee, P.O. Box 8737, Harrisburg, Pennsylvania 17105-8737.

II. Estimates of Children Needing and Receiving Mental Health Services

Numerous studies and reports estimate the number of children nationwide who need and receive mental health services. One report, *Youngsters' Mental Health and Psychosocial Problems: What Are the Data?*[1] has synthesized the "best" available data on children's mental health, while pointing out the limitations and deficiencies of the data. According to the report, such limitations include:

- lack of funding to support gathering mental health data;
- sound methodological practices are difficult and costly to implement;
- available information on prevalence and incidence of mental health and psychosocial problems and related service provision varies in quality and quantity; and
- too little investment has been made in gathering and aggregating mental health data.

This report includes four primary sources[2] of published data on youth mental health disorders. Overall prevalence rates[3] for some type of a diagnosable disorder were as follows:

- 21.4 percent for 2-5 year-olds;
- 20.3 percent for 9-11; and 13-year-olds; and
- 32.8 percent for 9-17-year-olds.

Various other reports and agencies cite the prevalence rates for mental health disorders in children and adolescents. These reports typically find about 5 percent of children have a serious emotional disturbance (SED), and about 11 percent have a mental health problem that is serious enough to cause some type of significant functional impairment.

Report of the Surgeon General's Conference on Children's Mental Health. According to this report, the U.S. is facing a public health crisis in mental health for infants, children, and adolescents. The report states that one in ten children and adolescents suffers from mental illness severe enough to cause some level of impairment.

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[1] *Youngsters' Mental Health and Psychosocial Problems: What Are the Data?* Center for Mental Health in Schools, revised June 2005.

[2] These four reports are: (1) Lavigne, et al. (1996) *Prevalence Rates and Correlates of Psychiatric Disorders Among Preschool Children*; (2) Costello et al. (1996) *The Great Smoky Mountains Study of Youth: Goals, Design, Methods, and the Prevalence of DSM-III-R Disorders*; (3) Shaffer, et al. (1996) *The NIMH Diagnostic Interview Schedule for Children, Version 2.3 (DISC-2.3): Description, Acceptability, Prevalence Rates, and Performance in the MECA Study*; and (4) Kessler et al. (2005) *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication.*

[3] Mental disorders in most of the studies include anxiety disorders, depressive disorders, behavioral disorders, and comorbid emotional/behavioral.

Report of the President's New Freedom Commission on Mental Health. President Bush announced the creation of the New Freedom Commission on Mental Health in 2002 to address the problems in the current mental health service delivery system. The report addresses gaps in the system and makes recommendations to eliminate them.[4] The report estimates that, in any given year, from 5 to 7 percent of children suffer from serious emotional disturbance, translating into millions of youngsters.

SAMHSA. According to the U.S. Substance Abuse and Mental Health Services Administration, at least one in five children and adolescents has a mental health disorder. At least one in ten, or about 6 million, children and adolescents have a serious emotional disturbance.

InCrisis. InCrisis provides analysis and screening services for parents and caretakers with children who do not have timely or affordable access to qualified mental health care services. It cites the MECA (Methodology for Epidemiology of Mental Health Disorders in Children and Adolescents) study's estimates for prevalence of mental health problems in children based on 2000 census population:

- 8.4 million children (21 percent) had a diagnosable mental or addictive disorder associated with at least minimal impairment;
- 4.3 million children (11 percent) had a diagnosable disorder associated with significant functional impairment; and
- 2 million children (5 percent) had a diagnosable disorder associated with extreme functional impairment.

InCrisis reports that the Friedman et al.[5] estimate for children with SED is approximately 5 to 9 percent of children, ages 9-17.

Based on these reports, we estimated that approximately 146,000 Pennsylvania children (5 percent of 2.9 million) have a serious emotional disturbance, and approximately 321,000 Pennsylvania children (11 percent) have a mental disorder serious enough to cause a significant functional impairment.

Literature also shows that children with mental health diagnoses are being underserved. The Surgeon General's 1999 report on mental health stated that an estimated 6 to 9 million children with serious emotional disturbance are not receiving the help they need–especially those from low-income families. Both this report

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[4] Some of the recommendations from this report include: address mental health with the same urgency as physical health; involve consumers and families fully in orienting the mental health system toward recovery; improve access to quality care in rural and geographically remote areas; improve and expand school mental health programs; advance evidence-based practices using dissemination and demonstration projects; and develop and implement integrated electronic health record and personal health information systems.

[5] Friedman, RM et al. *Prevalence of Serious Emotional Disturbance in Children and Adolescents.* In RW Manderscheid & MA Sonnenschein (eds.), Mental Health, United States, 1996 (pp. 71-86), Rockville, MD, Center for Mental Health Services.

and a 2003 GAO report warn that often children are in either child welfare or juvenile justice systems inappropriately because parents often have difficulty obtaining mental health services. Another study indicates that up to two-thirds of children with psychiatric disorders do not receive treatment.

Table 1 shows how many children received mental health services through Pennsylvania's Medicaid (Medical Assistance) program during CY 2003. It is important to note that these figures include only children served through Medical Assistance and do not include those served through the Commonwealth's CHIP program, other types of private coverage, or private pay.

Table 1

Percentage of Children Receiving Mental Health Services Paid for by Medical Assistance in the United States and Pennsylvania*

		Children Expected to Be Served		Children Actually Served		
Name	Total Population Under 18	Youth With Significant Impairment (11%)	Youth With Severe Impairment (5%)	Number Served	% of Significantly Impaired (11%) Population Served	% of Severely Impaired (5%) Population Served
United States	72,293,812	7,952,319	3,614,691			
Pennsylvania	**2,922,221**	321,444	146,111	99,809	31%	68%

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*Please note that the data includes only Medical Assistance children served. CHIP and private payor clients would increase the percentages of children served. However, the MA loophole (See Chapter IV.D) causes children to be served principally through Medical Assistance.

Source: Developed by LB&FC staff using DPW OMHSAS and U.S. Census data.

The percentage of Pennsylvania children receiving MA mental health services in CY 2003 ranged from about 1 percent of all children (Bucks, Chester, and Clearfield counties) to about 6 percent (Fayette, Greene, McKean, Mercer, and Philadelphia counties).

Counties Report That the Need for Mental Health Services for Children Is Increasing

Increases in mental health needs are especially true as regards autism spectrum disorder and post traumatic stress syndrome. These trends result in part from improved screening and identification and also reportedly because of the exposures of youth to certain risk factors not present in earlier years. For example, family functional issues and in utero risk factors reportedly have increased.

Several of the counties we visited, including Westmoreland and Luzerne, expressed concerns about their growing populations of children with mental health issues and the commensurate increase in the demand for children's mental health services. Officials informed us that juveniles are increasingly entering the system with ADHD, opposition disorder, and related conduct disorders. In Delaware County, over the past several years, the number of MA enrollees has increased from approximately 40,000 to 69,000. One possible explanation offered is more referrals from early intervention programs. Another is that people who are moving into Delaware County from Philadelphia generally have lower incomes, thus resulting in more children qualifying for MA services.

Chester County is also realizing significant increases in its juvenile population needing mental health services. The county is enrolling more children with autism. Officials informed us that people move to Chester County because it has a good reputation for service delivery. Chester has three times more "loophole" children (see Chapter IV.D) than any other county served by the Community Care Behavioral Health Organization, a Medicaid managed care organization. As of August 2005, the county reported serving 100 more children receiving wraparound services, an increase from 300 to 400 from the previous year.

Various studies also indicate that rates for mental illness are increasing. One report[6] indicates that of all pediatric visits from 1979 - 1996, the prevalence of psychosocial problems of children 4-15 had increased from 7 percent to 14 percent. In the Surgeon General's report, *Call to Action to Prevent Suicide*, the rate of suicide of children aged 10-14 is reported as having increased nationally by 100 percent from 1980-1996. In addition, data from the 1997 Client/Patient Sample Survey conducted by SAMHSA showed that more than 1.3 million children (or one out of 50) received mental health services. This is almost double the estimated number of children who received services in 1986, representing a 70 percent increase in the rate at which children received services in an 11-year period.

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[6] Kelleher, KJ et al. *Increasing Identification of Psychosocial Problems: 1979-1996,* Pediatrics, 105,6, 1313-1321.

III. Availability, Coordination, and Effectiveness in the Delivery of Mental Health Services for Children and Youth

A. Mental Health Services for Children Are Not Well Integrated, But Initiatives Are Underway to Address This Problem

In Pennsylvania, as throughout the United States, children's mental health services were very limited prior to the 1960s, with some children's units in state hospitals and few publicly funded community services. When, in 1963, federal community mental health legislation passed, Pennsylvania began a process for developing community MH/MR services legislation. Pennsylvania's Mental Health and Mental Retardation Act of 1966 provided the foundation for the development of the service system in which the state provides most of the funding, and county government serves as the local managing organization. This system, however, was focused on adults, not children. Children's services, however, continued to evolve in Pennsylvania, with group residential treatment facilities and family-based services introduced in the 1980s. In 2003, DPW reestablished the Bureau of Children's Behavioral Health Services, which had been defunct since 1997.

According to a 2005 article in *American Psychologist,*[1] children's mental health services in the United States are in crisis. The authors point out that this has been the case for the last 20 years and that the situation is only growing worse. The President's New Freedom Commission Report, issued in 2003, also found the nation's mental health system to be inadequate. The report recognizes that there are many barriers and unmet needs within the system and calls the nation's mental health services and supports "fragmented, disconnected and, often inadequate." The authors recommend a fundamental transformation, rather than a piecemeal approach, to improve the mental health service delivery system.

The American Psychological Association's Task Force on Psychology's Agenda for Child and Adolescent Mental Health came to a similar conclusion regarding the state of the nation's mental health system for children. The Task Force concluded that the incidence of child and adolescent mental health problems constitutes a public health crisis and that this crisis causes extensive human and financial costs that affect children, families, schools, communities, and, ultimately, the nation as a whole. The chair of this task force stated that, "There is a more universal recognition that we face an epidemic of children's mental health problems in this country."

A recent report from the National Alliance on Mental Illness (NAMI)[2] graded the states on their mental health systems, inclusive of both adults' and children's

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[1] Tolan and Dodge, "Children's Mental Health as a Primary Care and Concern," *American Psychologist,* September 2005, Vol. 60, No. 6, 601-614.

[2] NAMI is a grassroots mental health organization whose mission is the eradication of mental illnesses and improving the quality of life of those whose lives are affected by these diseases.

systems. NAMI's overall grade for the states was a D; Pennsylvania's grade was only slightly better, a D+ overall. Pennsylvania received a C- for "infrastructure, services, and recovery supports" and a D- for "information access." The report acknowledges recent innovations in the system, such as elimination of restraints and implementation of evidence-based practices, but also points out urgent needs, such as funding and better information access.

Structural Bifurcation and Impediments

The President's New Freedom Commission on Mental Health's 2002 Interim Report, while finding that the mental health system for adults is fragmented, noted that:

> The service system in many communities is *more fragmented* for children than that for adults, with even more uncoordinated funding streams and differing eligibility requirements. This problem is partly the unintended result of good intentions: there are more programs set up to serve children than adults. But this leaves coordination up to families who are coping with their children's behavioral problems and who may not have the knowledge to navigate the maze. All of the problems are disproportionately worse for children who are ethnic and racial minorities.

Although Pennsylvania has made advances in providing juvenile mental health services, the system is still complex and disjointed, with different programs—such as child welfare, foster care, juvenile justice, mental health, drug and alcohol, and schools—often having separate intake, screening and diagnostic processes and case managers. These systems also often have different treatment approaches, funding sources, and data collection systems.

Partnerships among these agencies and organizations are important to meet both the educational and mental health needs of children. A report from the U.S. Department of Health and Human Services concluded that effective collaboration between schools, families, social services, health, mental health, and juvenile justice can result in greater school retention and improved educational, emotional, and behavioral development for children with serious emotional disturbances.

Agencies and Programs Providing Child Mental Health Services[3]

Department of Public Welfare. The Department of Public Welfare operates several programs that provide mental health services to children through the Office of Mental Health and Substance Abuse Services (OMHSAS), the Office of Medical Assistance Programs (OMAP), and the Office of Children, Youth and Families (OCYF).

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[3] See Chapter IV.A for information on the funding for the specific Commonwealth agencies.

Office of Mental Health and Substance Abuse Services. The Department of Public Welfare provides mental health services to juveniles primarily through the Medical Assistance (MA) program administered by OMHSAS through Health-Choices, and administered by OMAP through Fee-for-Service. In the 1990s, DPW introduced managed care, called HealthChoices, for MA recipients for both physical and behavioral health care. According to DPW, in CY 2003 about 65 percent of the juvenile MA population—including almost 65,000 children aged 17 and under—was covered under HealthChoices, with the remainder in the fee-for-service program. Children may qualify for Medical Assistance based on their own income, thus entering the system as a 'family of one' (See Chapter IV.C pertaining to "loophole" children).

Although HealthChoices covers both physical and behavioral health, the two components are administered differently. The physical health component is provided by HMOs under contract to DPW (administered in the Office of Medical Assistance), whereas behavioral health services are provided through contracts with the participating counties that utilize independent managed care organizations. The behavioral health component is overseen by OMHSAS. Exhibit 1 shows which counties currently have HealthChoices; all other counties are fee-for-service. As of May 2006, DPW was expanding the program to the entire state to be implemented by July 2007. (See also Chapter IV.A.)

Exhibit 1

HealthChoices Oversight

County	Oversight	MCO/ASO[a]	Comments
Bucks	Bucks Co. Behavioral Health	Magellan Inc. of PA	Full Risk Subcontract
Chester	Chester Office of Behavioral Health	Community Care Behavioral Health	Full Risk Subcontract
Montgomery	Montgomery Office of Behavioral Health	Magellan Inc. of PA	Full Risk Subcontract
Delaware	DelCare	Magellan Inc. of PA	Full Risk Subcontract
Philadelphia	City of Philadelphia	Community Behavioral Health	County Operated 501C-3 Behavioral Health Organization; County Retains Full Risk
Allegheny	Allegheny County Health Choices, Inc.	Community Care Behavioral Health Organization	Full Risk Subcontract
Beaver	Beaver County	ASO With Value Behavioral Health of PA	ASO Contract With VBH of PA; County Retains Full Risk
Fayette	Fayette County	ASO With Value Behavioral Health of PA	ASO Contract With VBH of PA; County Retains Full Risk
Greene	OMHSAS	Value Behavioral Health of PA	MCO at Full Risk
Southwest 6: Westmoreland, Washington, Indiana, Armstrong, Butler, Lawrence	Southwest Behavioral Management, Inc. Each county also has oversight responsibilities.	Value Behavioral Health of PA	Full Risk Subcontract
Berks	Berks County	Community Care Behavioral Health Organization	Full Risk Subcontract
York/Adams	York/Adams County	Community Care Behavioral Health Organization	Full Risk Subcontract
Lehigh	Lehigh County	Magellan Inc. of PA	Full Risk Subcontract
Northampton	Northampton County	Magellan Inc. of PA	Full Risk Subcontract
Capital 5: Dauphin, Cumberland, Perry, Lancaster, Lebanon	Capital Area Behavioral Health Collaborative	Health Assurance Community Behavioral Care Network of PA	Full Risk Subcontract

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[a] ASO is administrative services only.

Source: DPW website.

The juvenile behavioral health system provides a broad array of services to children, including many services that are not available through private or commercial insurance. Types of services available are included in Exhibit 2.

In addition to the MA program, the Pennsylvania Mental Health and Mental Retardation Act of 1966 requires counties to provide an array of community-based mental health services. These services are also administered by OMHSAS through county MH/MR program offices. There are 48 county MH/MR programs that encompass all 67 counties of the state. The county offices generally contract with local mental health providers to provide direct services.

Exhibit 2

Behavioral Health Services Provided Through OMHSAS and OMAP

- Pre-treatment:
  - Student Assistance Program (with PDE and DOH)
  - Child Find and IDEA (with PDE and DOH)
  - Early Intervention Services (with DPW/OCD and PDE)
- Treatment:
  - Outpatient – individual, group, family, specialized office-based
  - Psychological counseling
  - Psychiatric evaluation
  - Psychiatric medical management
  - Psychological services
  - Wraparound services (mobile therapy, behavior consultant, TSS, and other)
  - Family Based Services
  - Partial Hospitalization
  - Residential Treatment Facilities
  - Psychiatric Emergency Centers
  - Psychiatric Hospitals
- Non-Treatment Services
  - Case Management
  - Mobile Crisis Services

Source: Developed by LB&FC staff with information provided by DPW and PCPA.

Office of Children, Youth and Families. The Office of Children, Youth and Families (OCYF) supports, through the county children and youth offices, a broad range of services to prevent and address child abuse, neglect, and youth and family violence. In its FY 2006-07 budget presentation, DPW estimated that 286,131 children will receive services by the child welfare and juvenile justice system during the fiscal year.

Eligibility for child welfare service is based on each child's need for service, as determined by the county children and youth agency and the juvenile probation office. Services provided include: placement, prevention, and family reunification; adoption assistance; emergency and planned temporary placement; foster care; child protective services; and other services ordered by the court for dependent and delinquent children. The Department provides reimbursement for expenditures the county incurs in providing children and youth services based upon the type of service delivered.

OCYF licenses a variety of residential facilities for children under the 3800 regulations. These facilities include not only traditional residential settings such as group homes and maternity homes, but also alternative programs and settings such as boot camps, outdoor wilderness programs, and transitional living residences. As of June 2006, DPW lists 944 facilities/programs licensed to provide over 17,000 beds and included in this total are 96 in-state JCAHO accredited RTFs and

42 non-accredited RTFs. These RTFs are licensed to provide up to 4,751 beds. The actual number of beds in use for any facility varies with need and provider staffing levels and is less than the total licensed capacity.

OCYF also has direct responsibility for the Youth Development Center/Youth Forestry Camp system, which provides secure residential programs for the treatment of Pennsylvania's most troubled delinquent population. The YDC/YFC system is comprised of nine facilities located throughout the state; eight facilities are operated directly by Commonwealth employees, and one facility is operated by a private provider under contract to DPW.

Many of the facilities have specialized programs for youth with specific or co-existing disorders, such as drug and alcohol abuse or severe emotional problems.[4] For example, New Castle YDC has a 24-bed unit for delinquent youth with co-occurring drug/alcohol and mental health disorders as well as a 12-bed unit for emotionally disturbed youth. Loysville has a 16-bed Specialized Treatment and Rehabilitation (STAR) program providing services to delinquent youth with mental health problems. The facility also has three cottages serving delinquent youth who exhibit immature, impulsive, or antisocial behavior. The Danville Center for Adolescent Females (to become The Girls Program at Danville) provides intensive treatment for girls who have experienced significant trauma, abuse, or self abuse; and the Cresson Secure Treatment Unit provides specialized services to a limited number of youth with emotional problems. OMHSAS estimates that at least half of youth between the ages of 12 and 18 in the Pennsylvania juvenile justice system have an emotional disturbance.

As of April 2006, OCYF was collaborating with OMHSAS on a Systems of Care grant from the federal government focusing on individualized care for children in the child welfare system with serious emotional disturbance. It was also working with OMHSAS on screening and assessment for behavioral health issues of youth in the juvenile justice system.

Department of Education. The Bureau of Special Education and the Bureau of Community and Student Services in Pennsylvania's Department of Education provide program and financial support to mental health services for students.

Student Assistance Program. Pennsylvania's Student Assistance Program (SAP) began in 1984. It is intended to identify and refer high risk students who are having school problems due to mental health or substance abuse problems. SAP is currently available in every school district in the state and is jointly funded by DPW.[5]

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[4] DPW's Bureau of Juvenile Justice Services recently reported that it is working with OMHSAS to develop protocols to move youth out of YDCs to more appropriate clinical settings. Accordingly, DPW is requesting MacArthur Foundation funds for this initiative.

[5] Legislation passed in December 2005 amended the School Code to require that "all school entities shall plan and provide for a student assistance program under the Early Intervention Services System Act."

The SAP core team is usually composed of school personnel, such as teachers, counselors, administrators, or nurses, and community liaisons, such as the county mental health agency and the drug/alcohol agency. These teams are trained to identify problems, determine if the problem is the responsibility of the school, and make recommendations for an assessment. When the problem is outside the school's responsibility, the team is to inform the parent of the problem, provide information on community resources to deal with the problem, and when necessary, help to establish links with those resources.[6]

According to school district reports to PDE, more than 82,500 children statewide received SAP referrals in the 2003-04 school year. Of those students referred 21 percent were enrolled in special education. Funding for SAP comes from federal Safe and Drug Free Schools grants,[7] the Safe School Initiative, the Accountability Block Grant, and local school district funding.

Alternative Education for Disruptive Youth Program. Alternative Education for Disruptive Youth programs are designed to remove disruptive students[8] from regular school settings and to provide an educational course of study and counseling to modify the disruptive behavior, with the goal of returning the students to a regular classroom. Such programs may be implemented by a school district, an area vocational-technical school, a combination of school districts, a charter school, or an intermediate unit. Schools may operate their own program or contract with a PDE-approved private provider for the program.

Funding for this program comes from the state Safe and Alternative Schools grant. For the 2005-06 school year, Alternative Education for Disruptive Youth grants totaling almost $20 million from a $23.3 million appropriation were awarded to more than 645 programs across Pennsylvania.

Child Find. Child Find is mandated by the Individuals with Disabilities Education Act. IDEA requires all states to have a "comprehensive Child Find system" to assure that all children who are in need of early intervention or special education services are located, identified, and referred for services.

In Pennsylvania, Child Find is the responsibility of the local education agency (LEA). The LEA reports annually to PDE on the children who are being served and what services are being provided. See Appendix B for information about

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[6] Parents contacted during this study often told us that when they first contacted the school district for help with their child, the school district told them the child was not having a problem in school and that the school district was not able to help. No assistance or guidance as to how to access the mental health system for the child was offered.

[7] The most recent federal budget request includes cuts to the Safe and Drug Free Schools funding that would impact PDE's funding for the SAP program.

[8] A disruptive student is one who poses a clear threat to the safety and welfare of other students or the school staff, who creates an unsafe school environment, or whose behavior materially interferes with the learning of other students or disrupts the overall education process.

a settlement agreement in Gaskin v. PA related to education for students with disabilities.

Early Intervention (EI). Early Intervention in Pennsylvania is a collection of services and supports designed to help children with developmental delays. DPW is responsible for the Early Intervention Program for children from birth to 3 years of age, including children with emotional delays. PDE is responsible for the program for children from age 3 to the age of beginners. PDE's program has focused primarily on children with physical problems that contribute to developmental delays, but recent PDE initiatives will also include children with serious emotional disturbance. One of these initiatives addresses a recommendation developed by the Governor's Commission for Children and Families to advance children's mental health and well being.

Recently, the DPW EI program was moved from the Office of Mental Retardation (OMR) to the Office of Child Development (OCD). With the joint appointment of the deputy secretary for OCD as PDE policy director, this is allowing the development of a more integrated and cohesive approach for all early childhood education services.

Additionally, in early 2006, the Deputy Secretary of OMHSAS and the Deputy Secretary of OCD were involved in new initiatives to develop a continuum of services for children from birth to age 5 and to ease the transition into school-based services. DPW and PDE staff have been meeting regularly to resolve administrative issues that are barriers for smooth transitions, and develop joint policy and service guidelines that promote common service delivery across both Early Intervention programs, and to determine the most effective strategies to assure behavioral health services for young children in EI. The Departments jointly issued new Early Intervention Guidelines on Transition at Age 3, which includes timelines and requirements for the transition process and strategies for increasing the quality of transition plans. Both departments report that they have high expectations for these collaborative efforts.

Special Education. Although special education activities focus on educational programming, mental health and emotional support services are also integral to successful educational development. PDE has recently, as discussed later in this chapter and also in Chapter V, taken initiatives to address gaps in mental health services in special education settings. There is increasing recognition of the need for improved integration of mental health and educational services.

According to a PDE published data, 14.4 percent of Pennsylvania's 1.8 million children in public schools have been identified as having a disability. This number is growing 4/10 of 1 percent each year. Students with emotional disturbance comprise 9.6 percent of the population of students with disabilities.

School districts and intermediate units throughout the Commonwealth have developed their own programs designed to address the mental health needs of their students. School based behavioral health services can range from screening and prevention programs, such as SAP, to therapeutic support classrooms.

The following examples describe some of the types of programs that may be available and that school districts are using to varying degrees.

- The Therapeutic Support Classroom Model, as developed, for example, in East Pennsboro Area and Pittsburgh School Districts, provides a comprehensive treatment program that addresses the student's academic needs, behavior problems, and mental health concerns within the school setting. Typically, each therapeutic support classroom has a special education teacher, a mental health therapist, a behavioral care staff person, and an education para-professional who work as a team. Placement in the therapeutic classroom is a transition step toward a less restrictive program, with the ultimate goal for the student to develop the skills to transition into the mainstream classroom.
- The Colonial Intermediate Unit has established a school-based partial hospitalization program in 20 schools within its territory. The local school districts provide the classroom space. Two special education teachers and two mental health workers per classroom provide education and treatment concurrently in the school setting.
- The Western Psychiatric Institute and Clinic provides school-based mental health services in Pittsburgh area schools. This program provides prevention and early intervention services in the schools to children K-12. Outpatient therapy is also offered in certain schools.[9]

PDE does not specifically track the types of programs provided by individual school districts. PDE has made certain recent efforts to collect data on mental health services in schools and to serve as a clearinghouse for this type of information. However, information about emotional support needs is tracked by PennData and shows that, statewide, 9.6 percent of special education students present with emotional disturbances. Table 2 provides additional information on students with emotional disturbances by intermediate unit.

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[9] Other PDE reported successful programs include: Steps (Special Treatment/Enhancement Program for Success), Central Dauphin School District; Family, Education & Treatment: A Student's Bridge to Success (School Based Partial Hospitalization), Wallenpaupak School District; Integrated Building Level Teams, Northwest Tri-County Intermediate Unit 5, Edinboro, PA.

Table 2

Number of Special Education Students With Emotional Disturbance by IU

IU	IU Name	Special Education Students	Emotional Disturbance	Emotional Disturbance as % of Special Education
1	Intermediate Unit 1	8,929	1,021	11.4%
2	Pittsburgh-Mount Oliver IU 2	6,412	1,004	15.7
3	Allegheny IU 3	18,489	2,264	12.2
4	Midwestern IU 4	8,493	743	8.7
5	Northwest Tri-County IU 5	9,716	1,003	10.3
6	Riverview IU 6	4,760	362	7.6
7	Westmoreland IU 7	6,850	517	7.5
8	Appalachia IU 8	8,977	642	7.2
9	Seneca Highlands IU 9	2,195	121	5.5
10	Central IU 10	4,325	342	7.9
11	Tuscarora IU 11	2,629	247	9.4
12	Lincoln IU 12	13,748	1,498	10.9
13	Lancaster-Lebanon IU 13	14,079	1,223	8.7
14	Berks County IU 14	9,931	958	9.6
15	Capital Area IU 15	13,384	1,360	10.2
16	Central Susquehanna IU 16	4,842	299	6.2
17	BLaST IU 17	5,474	322	5.9
18	Luzerne IU 18	6,416	454	7.1
19	Northeastern Educational IU 19	7,600	595	7.8
20	Colonial Northampton IU 20	11,493	1,084	9.4
21	Carbon-Lehigh IU 21	8,056	847	10.5
22	Bucks County IU 22	13,801	1,168	8.5
23	Montgomery County IU 23	15,526	1,565	10.1
24	Chester County IU 24	10,633	961	9.0
25	Delaware County IU 25	13,163	1,581	12.0
26	Philadelphia IU 26	27,402	2,743	10.0
27	Beaver Valley IU 27	3,735	326	8.7
28	ARIN IU 28	3,496	228	6.5
29	Schuylkill IU 29	3,253	364	11.2
	Total	267,807	25,842	9.6%

Source: PDE Bureau of Special Education.

PDE believes that partnerships between LEAs and behavioral health organizations are the best way to address the mental health needs of students. PDE and DPW are therefore encouraging school-based services through partnerships with community providers or licensure, depending on the needs of the community. This will allow the LEA to provide both educational and mental health services in the school setting. Examples of programs where the LEA is a licensed provider can be found in Capital Area IU 15, Colonial IU 20, Chester County IU 24, Schuylkill County IU 29, and the Hazleton School District.

Department of Health. Drug and alcohol services are provided through the Bureau of Drug and Alcohol Programs (BDAP) within the Department of Health.

However, these programs are mainly targeted toward adults, and, according to BDAP officials, drug and alcohol programs for juveniles are very limited. In an effort to address this issue, BDAP applied for a federal grant to hire a staff person to coordinate and improve the adolescent system. The goal of the grant was to ease funding restrictions among departments in an attempt to provide comprehensive treatment planning and service delivery. BDAP, however, did not receive the grant.

Juvenile Justice and Related Agencies. National studies estimate that 40 to 50 percent of the youth in the juvenile justice system suffer from a mental or emotional disorder. These mental health problems likely play a role in the offending behavior that leads to the juvenile justice system. Juvenile facilities, however, are often not equipped to diagnose and treat youth suffering from mental and emotional disturbances, and accessing mental health services for youthful offenders can be a complicated process.

As of May 2006, an initiative was underway to address this problem in Pennsylvania. The mental health project of the Juvenile Detention Centers Association of Pennsylvania (JDCAP) has focused on administering the MAYSI-2 to youth entering juvenile detention centers throughout Pennsylvania. This screening tool is used to identify youth who may have behavioral health needs as they enter the juvenile justice system. Chapter III.C of this report discusses this project in greater detail.

The Pennsylvania Commission on Crime and Delinquency (PCCD) works to improve the criminal and juvenile justice systems in part by promoting interagency coordination and cooperation and providing training. PCCD distributes grant funding for juvenile justice and delinquency prevention projects with a mental health component. These grants have helped fund projects to demonstrate the effectiveness of various strategies, including Functional Family Therapy (FFT), Multisystemic Therapy (MST), Multidimensional Treatment Foster Care, and Brief Strategic Family Therapy. PCCD funding for FFT and MST have totaled over $9 million over the last several years. See Chapter IV.A for information on recent grant amounts.

State Actions and Initiatives to Improve the Children's Mental Health System

Through a variety of initiatives, including those described below, both the state and counties are attempting to break down the "silos" that exist between different programs and offices. This includes greater efforts at collaboration between offices within DPW (OMHSAS and OCYF), PDE, and program offices at the county level.

Child and Adolescent Service System Program (CASSP)

Until the early 1980s, most mental health services were adult-focused, with little attention paid to children's needs. In 1985, Pennsylvania was awarded a federal CASSP grant. The goal of CASSP is to improve and develop a comprehensive, coordinated, and collaborative system of services to children and their families with multisystem needs and is based on the premise that the mental health needs of children cannot be met by the mental health system alone because children are influenced by many aspects of their lives, not just mental health needs. The six principles of CASSP are:

- *child-centered*: services meet the individual needs of the child, consider family and community contexts;
- *family-focused*: services recognize that the family is the primary support system and participates in decision making and treatment;
- *community-based*: services are delivered in the child's home community;
- *culturally competent*: services recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices of the child's ethnic group;
- *multisystem*: services are planned in collaboration with all the child-serving systems involved in the child's life; and
- *least restrictive / least intrusive*: services take place in settings that are the most appropriate and natural for the child and are the least restrictive and intrusive to meet the needs of the child.

The CASSP infrastructure in Pennsylvania includes a statewide advisory committee comprised of families, advocates, and professionals, as well as county-level advisory committees. In addition, there is a statewide CASSP coordinator as well as a coordinator in every county. There are regional CASSP contacts in each of the four OMHSAS field offices. OMHSAS also funds the Pennsylvania CASSP Training and Technical Assistance Institute, the purpose of which is to provide leadership and address the human resource needs in clinical best practices for serving children and adolescents.

When a child or adolescent is identified as having mental health needs and requires the services of other systems as well, a CASSP team is convened to discuss the options for treatment, care and support. The team consists of all the key players in the child's or adolescent's life, including family members and professionals from all of the child-serving systems involved.

Pennsylvania's CASSP Institute, partially funded by OMHSAS, is housed in the Department of Psychology at Penn State University. Its mission is to improve the clinical practice of children's mental health workers in the public sector and build capacity in the workforce. The Institute offers training and technical assistance and holds an annual CASSP conference. Since FY 1997-98, there have been over 22,000 participants in these events. An average of over 1,800 mental health workers, including county officials and private providers, attend a CASSP training session each year; an average of 200 enroll in technical assistance offerings. (See also Chapter V for additional information on the Institute.)

Systems of Care

The Systems of Care (SOC) approach to providing services to children with mental health issues was designed to help build comprehensive service systems that allow children with emotional disturbance to receive a comprehensive array of integrated, community-based services. This approach resulted from findings that showed that children's mental health services were fragmented and that many children were not receiving necessary services. The SOC philosophy is similar to that of CASSP, however, CASSP is funded through OMHSAS and SOC is funded through federal grants, which flow through OCYF.

The primary principles of Systems of Care are as follows:

- The mental health service system is driven by the needs and preferences of the child and family, using a strengths-based, rather than deficit-based, perspective.
- Family involvement is integrated into all aspects of service planning and delivery.
- The locus and management of services are built on multi-agency collaboration and grounded in a strong community base.
- A broad array of services and supports that emphasize treatment in the least restrictive, most appropriate setting, is provided in an individualized, flexible, coordinated manner.
- The services offered, the agencies participating, and the programs generated are responsive to the cultural context and other characteristics of the populations being served.

Initially, Systems of Care was funded in Pennsylvania in Allegheny and Philadelphia counties with a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Allegheny County's program is called Community Connections for Families (CCF) and targets children between 6 and 14 years old with serious emotional disorder (SED) who are involved in two or more social service systems. The goal is to improve coordination and service integration by overcoming the fragmentation that occurs between systems. In Philadelphia, Systems of Care principles were integrated with behavioral health managed care.

DPW's OCYF also received an SOC grant in 2003 from the federal Administration for Children and Families. The goal of the grant is for OCYF to organize a process for developing SOC practices with the county-based child welfare system. Dauphin County was the initial county for this grant, partly because of its willingness to organize its programming around SOC principles and practices. Nine counties received grants in March 2005, with 11 more responding to requests for proposals in June 2005, yielding 17 SOC counties.[10]

At the Third Biennial Research to Practice Forum held at Penn State University in March 2006, two Allegheny County officials gave a presentation on lessons learned in implementing a System of Care. According to these officials, under the county Systems of Care initiative, families have become more stable (e.g., number of inpatient hospitalizations are down) and children are getting better (e.g., overall child functioning improved significantly). The system engaged stakeholders from the beginning and is consumer driven. The county attributes much of the success of the program to consumer input and expertise, as well as SOC being a data-driven process. The Child and Family Team approach used in Arizona is similar to Systems of Care and was recently cited as a promising case management approach. See Appendix C for more information.

Integrated Children's Services Plan (ICSP)

DPW's ICSP initiative resulted from the concern of many counties, families, and professionals that services need to be provided in a seamless fashion. The purpose of the ICSP is to identify goals, strategies, and outcomes that counties can use to integrate these services. It creates a mechanism for agencies to plan together so that appropriate services can be accessed regardless of which 'door' a child may enter.

Each county develops its own plan for integrating services. Not only are counties to coordinate among their own human services agencies, but they are also to collaborate with school districts and early intervention programs, physical health care services, food stamps, and other public benefits programs. MA Realignment (see Chapter IV.C), wherein DPW, in part, is attempting to maximize federal dollars by allowing certain services to qualify for Medical Assistance funding, is one initiative that evolved from the ICSP process.

Counties submitted their first ICS plans for FY 2005-06 under guidance issued by DPW. The guidelines for FY 2006-07, submitted in August 2005, changed only slightly, with justification required for any new initiatives. The draft FY 2007-08 guidelines indicate that the Department has found that counties are operating on varying levels of integration, in part because some counties had been working with an interagency approach before the advent of the ICSP, while the concept is newer to other counties.

For FY 2007-08, DPW decided to approach counties and their plans on a two-tiered basis. The Tier One counties are those that have made substantial progress toward integrating children's services. (DPW will determine which counties qualify

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[10] Systems of Care counties include: Allegheny, Delaware, Elk, Lycoming, Northumberland, Jefferson, Armstrong, Luzerne, Erie, Cumberland, Juniata, Somerset, Mifflin, Indiana, Huntingdon, Venango, and Chester.

for Tier One status after reviewing county plan submissions.) These counties are to outline a plan for full integration that is to include, for example, a common assessment process for all children and families. Tier One counties will be eligible for incentive funds for implementing promising practices in several areas, including:

- Integrated case management
- Integrated data management
- Centralized intake
- Integrated prevention planning
- Other projects that will lead to substantial progress toward full integration of services

Tier Two counties are those that have achieved some cross-system collaboration, but in the opinion of the Department are not ready for full integration. These counties will not be eligible for incentive funds, but will be eligible for technical assistance to help them achieve Tier One status.

Model for Multisystem Planning. Allegheny County is an example of a county that has formalized its approach to interagency coordination and collaboration. The county's Department of Human Services has developed an approach, called County Interagency Review, to planning and implementing services for juveniles that involves all of its program offices, including the offices of Behavioral Health; Children, Youth and Families; Community Services; and Mental Retardation/Developmental Disabilities. The goal of the Allegheny system, which served 225,000 consumers in FY 2004-05, is to bring the managing agencies, providers, and consumers together to assure that an individual's needs are addressed through a full continuum of services. According to the county, it reduces system fragmentation, discontinuity of services, and conflict/competition over scarce resources.

As part of the Interagency Review, a Multisystem Rapid Response Team meets monthly to review cases; it also meets to address emergency situations. Most often, the Team is trying to find a solution for a juvenile with few options, that is, when all appropriate resources within existing service systems have been explored or when a needed service or resource can not be found. Funding for such services is determined after a placement or appropriate service is found. Similar efforts are underway in other counties.

Other Activities and Initiatives[11]

Children's Behavioral Health Task Force. DPW established two task forces to address two key child behavioral health initiatives. The first, a task force to deal with the needs of people with autism spectrum disorders, released its report in

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[11] Appendix D identifies two additional DPW and OCD initiatives intended to bring mental health consultation services to early learning programs.

December 2004 (see Chapter VII for the status of implementation of the task force's recommendations).

The second is the Children's Behavioral Health Task Force (CBHTF). The CBHTF was charged to develop recommendations to improve the delivery, management, and financing of children's behavioral health services. The CBHTF began its work in May 2004 with 300 participants, then expanded to over 700 participants, including families, providers, medical professionals, educators, and government officials. We engaged in discussions with DPW and CBHTF members during the course of this review in order to understand the Task Force's emphases and conclusions. As of May 2006, the draft report had gone through several iterations and was still in confidential draft stage with DPW executive staff. Stakeholders and advocacy groups reported to us that they have been anxiously anticipating the CBHTF report, which DPW reports is expected to be posted on DPW's website by June 2006 for public comment.

Governor's Commission for Children and Families. This Commission, formed by Executive Order in 2003, is to assist and advise the Governor's Cabinet on Children and Families. The ten-member cabinet, which is chaired by the Secretary of Public Welfare and includes the Secretaries of Education and Health, among others, is charged to make recommendations to the Governor on ways to improve delivery of services to children and families.

The Commission has two main priorities: (1) investing in effective multi-system prevention services and (2) easing access to services for families that desperately need help in a timely fashion. In March 2006, the Commission issued a position statement and offers recommendations in its *Actions to Improve Children's Mental Health and Well-Being*. These recommendations emphasize prevention and early intervention to reduce the risk and severity of mental health and developmental problems and increased collaboration and integration of child and family services (see Exhibit 3).

School-Based Behavioral Health Conference. PDE and DPW jointly sponsored a School-Based Behavioral Health Conference in early May 2006. The conference promoted the development and implementation of effective school-based behavioral health programs and services across the Commonwealth. National and state experts in school behavioral health discussed the issues and identified successful programs. The curriculum included a keynote address on "Seven Solutions to School-Based Mental Health Success" and workshops on prevention programs, school-based partial hospitalization, comprehensive school-based behavioral health programs, cross agency collaboration and planning, and family partnership in planning and support.

Transformation Facilitation. In March 2006, DPW entered into an initiative, Transformation Facilitation, sponsored by the Georgetown National Training and

Exhibit 3

Position Statement and Recommendations for Actions to Improve Children's Mental Health and Well-Being*

Governor's Commission for Children and Families

The Commission emphasizes that child mental health and well-being is very important and that multisystem collaboration is necessary. The Commission also believes that prevention is paramount and that building a continuum is critical. Its top five priorities and the recommendations to help achieve those priorities include:

1. Increase prevention and early intervention efforts to reduce the risk of and severity of mental health and developmental problems.
    a. Change reimbursement (Medicaid and CHIP) so that child's physician can be reimbursed for making available screening, assessment, and referral to an array of services and supports including treatment for a parent with depression.
    b. Behavioral health system (OMHSAS and BDAP) should make available uniform or standardized screening or assessment of the children of parents in treatment and effectively linking the children with indicated interventions.
    c. In addition to regular medical evaluations, children in out-of-home placements should have social/emotional and developmental assessments upon entering placement and at developmentally appropriate intervals (infancy, early childhood, middle childhood, and adolescence).
    d. For a child birth to age 3, Early Intervention (EI) agencies should implement the policy that the child is eligible upon "informed clinical opinion" when social emotional delays are not yet measurable.
    e. The eligibility standard for EI services should be the same for children from birth to school age—namely, that the child has a developmental delay and would benefit from any EI service.
    f. EI agencies should continue to identify and use assessment tools that are appropriate for screening and assessment for social or emotional delays.
    g. EI agencies and EITA should continue to provide training and technical assistance on best practices regarding social and emotional development, assessments, and interventions.
    h. To more fully serve children with emotional delays, simplify requirements, strengthen the family support aspects and assure that children, who are transitioning to the 3-5 program and in need of early intervention services, receive them.
    i. Ensure that both behavioral health and early intervention systems collaborate so that services are provided without creating barriers for families, either directly or through contracted agencies.
    j. Pennsylvania should clarify that only developmental delay in the social/emotional area qualifies a child for services.
    k. Enforce existing requirements that children are entitled to maintain their EI services when they turn three years of age, and when they reach school age should be enforced without the parents filing appeals. These provisions are known as "pendency" during transition.
    l. Continue current efforts to assure better alignment of programs (e.g., better integration, work with and train local entities, establish PDE/DPW guidelines issued on transition, etc.).
    m. Agencies responsible for EI and mental health should fund Child Find, screenings and assessments **<u>at</u>** early care and education sites when requested.

Exhibit 3 (Continued)

n. Local EI and mental health authorities should consult at least quarterly with the local elements of the state's early childhood education system to assess the need for EI and mental health services for children in early care and education programs.

2. Increase collaboration and integration of child and family services across (behavioral health, education, health care, child welfare, juvenile justice, and workforce development) systems.
    a. Ages 6-12: State provides categorical funding to implement consultation and assessment services for SAP programs in elementary schools.
    b. Ages 13-18: Expand the use of Teen Screen in Pennsylvania to identify depression and suicidal risks and assure the availability of timely and effective treatment services.
    c. Develop a strategy on how to incorporate social and emotional development into educational standards and programs in every school district.
    d. Establish a statewide hotline for pediatricians and family physicians to call to identify resources (EI, Mental Health (MH), Medical Assistance (MA), etc.) for patient families and consultations for the physicians.
3. Help families overcome difficulties accessing needed services in a timely fashion.
    a. Sustain and replicate effective Systems of Care projects and other community-based efforts that integrally engage parents in redesigning services to be more responsive to family needs.
    b. Establish and replicate successful parent and family advocacy models that have helped families find services and helped redesign services and strengthen policies throughout Pennsylvania.
    c. Establish and strengthen websites and one call numbers (2-1-1) so that families and people supporting them can find helpful services in the maze of agencies in a timely manner.
4. Provide more expenditures for proven or promising programs.
    a. Identify programs that work and programs that do not work and reallocate funds and invest new funds in services that we know work.
    b. Expand Medicaid reimbursement for evidence-based programs for children's mental health treatment.
    c. Expand training and technical assistance to transfer the knowledge of proven or promising programs to the counties or local programs.
    d. Expend funding and increase efforts to turn promising programs into proven programs.
5. Increase the number of professionals who will provide quality services to children experiencing mental health problems.
    a. Provide incentives (i.e., scholarships and sound loan forgiveness programs) to state training institutions to get more psychiatrists, psychologists, and mental health workers trained and retained in the state. Explore offering housing assistance, college tuition, and other incentives to attract and retain mental health professionals.

A recent article in *Health Affairs*, Beyond Integration: Challenges For Children's Mental Health, calls for actions similar to the Governor's Commission. It identifies five areas of policy changes that could improve the quality of children's mental health services, including: expanding evidence-based practices, addressing prevention and early intervention, integrating family perspectives into service delivery, strengthening accountability mechanisms and aligning fiscal practices with best-treatment practices.

Source: Developed by LB&FC staff using information obtained from the March 2006 Governor's Commission for Children and Families.

Technical Assistance Center for Children's Mental Health (NTTAC). The goal of this initiative, which is supported by SAMHSA's Child, Adolescent and Family branch, is to support states through technical assistance and consultation to identify and implement transformation goals for children's mental health. To support states in achieving transformation, the NTTAC will help states in:

- assessing the current status of mental health systems development;
- identifying transformation targets and strategic opportunities;
- facilitating collaborative alliances;
- developing action plans;
- providing process and content expertise;
- linking the state to written resources, experts and national events; and
- creating opportunities for peer-to-peer consultation and support.

Within this initiative, DPW anticipates working on several areas, specifically, prevention and early identification and intervention, child and family teams, development of the continuum of effective services, evidence-based practices, interagency integration, managed care, and youth suicide prevention.

DPW reports that other states are also exploring ways to refinance and improve children's mental health services. These initiatives include: looking for 'new' money, or maximizing Medical Assistance dollars; redirecting current spending, primarily through reducing residential treatment and/or moving money from services that produce poor outcomes; and developing a "locus of responsibility" whereby a care management entity is empowered to purchase needed services to address the needs of the most seriously mentally ill children.

Youth Suicide Prevention Activities. Although teen suicide rates dropped in Pennsylvania during the 1990s, the issue of youth suicide remains a concern in the Commonwealth. Between 2002 and 2004, 581 adolescents between the ages of 10 and 18 committed suicide in Pennsylvania. Over the last five years (2001-2006), every county experienced at least one youth suicide, with rural counties having some of the highest suicide rates. To address this situation, DPW, in collaboration with the Pennsylvania Network for Student Assistance Services, convened a workgroup of about 50 stakeholders from across the Commonwealth to formalize a Youth Suicide Prevention Plan, which includes a five-year action plan. This plan identified the existing efforts of the Commonwealth Student Assistance Program since 1986 and identified additional gaps. A Monitoring Committee was then established to ensure the implementation of the plan. The Monitoring Committee includes representatives from DPW (mental health, child welfare, mental retardation), PDE, DOH (substance abuse, health risk reduction), Child Death Review Team, JCJC, the STAR-Center, the MH/MR Administrator's Association, family representation (suicide survivors), a local Suicide Prevention Task Force, and the Mental Health Association of Southeast Pennsylvania. The need for the Committee arose following the development of the Youth Suicide Prevention Plan, which includes a five-year action plan that was developed by a work group from across the Commonwealth. To help meet the goals of the prevention plan and the five-year action plan, in May 2006, DPW submitted a grant proposal to SAMHSA for the development of suicide prevention programs in collaboration with the primary care medical community.

Restraint-Free Initiative. In early 2006, the DPW began implementing its goal of a "restraints free" environment, resulting, in part, from reports of injuries and deaths related to the use of restraints in Pennsylvania and elsewhere. DPW issued a "Special Transmittal" that provides guidance to staff at child residential and day treatment programs relating to the use of restraints,[12] which is in addition to regulations that already address the issue.[13] The Department conducted a "kick-off" orientation seminar in February 2006 to provide in-depth information about the "special transmittal" document, which states that the use of restraints is to be avoided whenever possible because of the risk of serious injury and/or death of a child, youth, or staff; emotional harm and trauma to the child, youth, or staff; and the disruption of relationships between the youth, family members, peers, and provider staff. Please see Appendix E for more information.

Other Task Forces and Advisory Groups

Various other task forces, work groups, and advisory groups have been created in recent years in an effort to better coordinate the agencies and programs providing mental health services to children. Exhibit 4 lists the groups that LB&FC staff have identified, worked with, or become knowledgeable about during this review. Several of the groups are statutorily or federally mandated. Some are general in nature and address more than just children's mental health; others are more narrowly focused on a particular problem area.

While the desire to establish mechanisms to improve coordination and information is understandable, we found signs that the sheer number of these advisory bodies may itself be creating problems. These task force/groups do not appear to function in a coordinated manner and frequently address similar issues, and many of the same persons sit on at least several of the bodies. At least one key stakeholder reported that he will no longer agree to sit on new task forces until the proliferation of these groups is controlled, noting that the issues the groups are charged to address are often redundant and can lead to additional coordination problems.

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[12] The Department of Public Welfare's Office of Mental Health and Substance Abuse issued a Mental Health and Substance Abuse Bulletin (OMHSAS-02-01) on April 8, 2002, that provides guidance to mental health facilities in moving toward a restraints-free environment.

[13] In April 2006, the Department of Public Welfare's Office of Mental Health and Substance Abuse Services distributed draft psychiatric Residential Treatment Facility (RTF) regulations that include the recent restraint provisions. The purpose of these regulations is to consolidate all DPW bulletin and regulatory requirements and federal requirements for accredited psychiatric RTFs. The current regulations will remain in effect for other types of facilities. The comment period is through May 24, 2006, and DPW plans to form a work group to respond to comments.

Exhibit 4

Children and Adolescent Mental Health Related Advisory and Task Force Groups

Governor's Commission for Families and Children

Integrated Children's Service Initiative Task Force

Children's Behavioral Health Task Force

Governor's Mental Health/Mental Retardation Advisory Committee

OMSHAS Advisory Council, Children's Committee[a, b]

MacArthur Advisory and Work Groups

Education in Partial Hospital Setting Work Group

Alternative to Coercive Treatment Work Group

Integrated Children Services Planning Advisory Group

Drug and Alcohol Advisory Council[a]

Youth Suicide Prevention Monitoring Committee

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[a] Statutorily or federally mandated.

[b] The OMHSAS Children's Advisory Committee formed a workgroup (composed partly of providers and family members) to develop comments for this report. Their comments included a compilation of documents that address the issues within the juvenile mental health system that the group determined to be deficiencies within the system over the last decade.

Source: Developed by LB&FC staff.

III.B. Outcomes Data for Juvenile Mental Health Services Is Lacking; More Evidence-Based* Type Approaches Are Needed

Outcome measures show whether results have been achieved within a certain program or, in the case of juvenile mental health, whether treatment modalities are effective at improving a child's condition. Many of the mental health services that children in Pennsylvania receive are not assessed for outcomes; that is, they have not undergone a study to determine whether the services are actually helping to improve children's mental health.

Because there is little knowledge about whether currently used treatment programs are working, there has been movement, both nationally and within Pennsylvania, to use more evidence-based treatment programs. Evidence-based programs are programs that have been empirically proven to produce positive effects.

Actions and Initiatives to Improve Accountability and Measure Program Effectiveness

Two Pennsylvania behavioral health care management organizations have undertaken efforts to measure outcomes for children receiving services, one measuring BHRS (wraparound) services in particular. In addition, DPW has implemented certain efforts to measure outcomes, and PDE and PCCD are also involved in such efforts. For example, PCCD provided grants to a variety of providers to help them with start-up costs associated with such interventions.

Department of Public Welfare Outcome Measurement Activities

IPRO. The federal Balanced Budget Act requires DPW to have independent external reviews of the Health Choices program; IPRO[1] received the contract to conduct such reviews, which occur annually. The overall objective of the reviews is to determine each behavioral health managed care organization's (BH MCO's) adherence to DPW's standards for timeliness, quality of care, and access to necessary care. To achieve this, IPRO identified three quality indicators to assess quality care in residential treatment facilities. Those quality indicators are:

- *Family Involvement in Residential Treatment Facility Care*: This indicator was included due to the policy position of the American Academy of Child and Adolescent Psychiatrists (AACAP) stating that "the participation of family members

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*The term "evidence-based" has different meanings. We use the term "evidence-based" for programs that are recognized as having well-defined procedures, use multiple outcome measures, and produce results that can be replicated in multiple settings.

[1] IPRO is an independent external quality review agency certified by the U.S. government.

in the assessment and treatment of infants, children, and adolescents is integral to positive clinical outcomes."[2]

- *Coordination of Outpatient Follow-up in Residential Treatment Facility Care*: Outpatient follow-up from inpatient psychiatric care has been shown to reduce re-hospitalization rates and the same may be true for follow-up from residential care. For an outpatient provider to facilitate optimal care, they need knowledge of both the treatments rendered during the RTF stay and the treatment plans.[3]
- *Medication Rationale Documentation in Residential Treatment Facility Care*: The use of psychotropic drugs in residential or inpatient settings for children has increased over the past few years. Medication use requires the careful weighing of risks and benefits, with the final decision to use medication clearly documented and justified. When care is transferred from one provider to another, this documentation becomes increasingly important. Without it, the subsequent provider may discontinue appropriate medication or continue inappropriate medication due to lack of information.

The findings for the three selected indicators also fell well short of performance goals, leading IPRO to recommend the adoption of a formal plan to improve data submission and monitoring programs. Improvement strategies developed by IPRO to address the poor outcomes of the review included:

- emphasis on documentation standards and protocols in the residential treatment facility settings; and
- education of health professionals, as well as changes in organization processes, to ensure that the actual services measured by all three quality indicators do occur.

These indicators were then re-measured in 2003 after allowing the BH MCOs the opportunity to implement suggested improvement strategies. Results from this re-evaluation indicated statistically significant increases in all three performance indicators; however, the performance goals set for the initial review were still not achieved (see Table 3).

The Department expects to return to this issue within the next two to three years with another re-measurement conducted by IPRO, according to an official within OMHSAS. As of May 2006, counties were working with the providers that participated in the initial and follow-up reports to assist in training staff in various competencies that are designed to help meet the goals set for each quality indicator. Future re-measurements beyond the next one will be based on the performance results of the next re-measurement.

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[2] This indicator was measured by calculating the percentage of enrollees discharged from a residential treatment facility during the measurement year whose parent(s) or legal guardian(s) were present for an on-site meeting within seven days of admission to the facility.

[3] This indicator measured the percentage of enrollees discharged from a residential treatment facility during the measurement year whose ambulatory mental health provider was sent documents regarding that patient's RTF care prior to the patient's discharge from that level of care.

Table 3

IPRO External Quality Review Results: 2000 & 2003

Quality Indicators	Performance Goal	2000 Results	2003 Results
Quality Indicator 1: Family Involvement	80.0%	42.3%	79.6%
Quality Indicator 2: Coordination of Outpatient Follow-up Care:	80.0	5.5	14.8
Quality Indicator 3: Medication Rationale Documentation	90.0	40.6	50.3

Source: Developed by LB&FC staff from DPW IPRO report.

Other Residential Treatment Facilities Outcome Measurement Activities.[4] As part of DPW's MA Realignment, representatives from DPW, JCJC, county human service agencies, and provider groups formed a Medicaid Realignment Integrated Children's Services Measures workgroup in March 2006. The group is determining how to measure the impact of the realignment on quality, access, and outcomes of children's mental health services, but was in the early stages of discussion as of May 2006. Because residential treatment facilities are a substantial part of the budget for child mental health services ($141 million in CY 2003), it is anticipated that the group will focus its efforts on RTFs.

The measures under consideration by the group on a pilot basis in Adams, Allegheny, Montgomery, Tioga, and Venango counties include:

- The median length of stay in care in an RTF for children receiving behavioral health services.
- The median length of stay in juvenile detention prior to an RTF admission.
- The number and percent of children receiving behavioral health services in the home or community versus those receiving them in an RTF.
- The number and percent of children that are adjudicated dependent or delinquent and who are receiving behavioral health services via Medical Assistance.
- The median length of time from date of referral to date of assessment.
- The median length of time from date assessment is received to date Medicaid-funded services begin.
- The median length of stay in home/community services.
- The median length of stay in an RTF.
- The percent of children who move from an RTF to a more positive setting (such as a less restrictive setting).

DPW officials noted concern over the lack of specific measures of the effectiveness of service in residential treatment facilities. Additionally, certain

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[4] In spring 2005, DPW also began efforts to gather case-specific information from children and youth administrators and chief juvenile probation officers when local administrators encountered problems regarding the MA Realignment Initiative.

stakeholders reported that RTFs could be more successful if they did a better job in integrating youth back into the community. Use of more evidence-based therapeutic interventions is one key goal of the Medicaid Realignment Initiative, and the activities of the MA workgroup are envisioned as one step in that direction. But as shown above, the proposed measures do not directly assess the success of the residential treatment facility in improving children's mental health. We were also informed that Philadelphia Community Behavioral Health (CBH), the HealthChoices managed care organization, is also attempting to determine how to measure the outcomes of RTFs within their network.

Annual Plan Review. Each year, as part of its oversight of behavioral health managed care plans, DPW undertakes an in-depth review of a particular aspect of the behavioral health HealthChoices Program. For example, a review might look at BHRS services in the southeast or inpatient psychiatric services in the southwest.

The report issued in January 2005 provided a review of clinical records and on-site interviews with clinical staff in the counties of Armstrong, Butler, Indiana, Lawrence, Washington, and Westmoreland and examined four levels of care: inpatient, RTFs, BHRS, and family-based services. The January 2005 report found that documentation for three levels of care, the intensity of BHRS, and the length of stay met established review criteria in the majority of cases but that documentation of medical necessity for family-based services was far below established criteria.

HealthChoices Managed Care Organization and Provider Initiated Outcomes Reviews

Two Medicaid behavioral health managed care organizations, Magellan and CBHNP, have undertaken their own reviews of juvenile mental health services in HealthChoices in Pennsylvania, and one provider organization is developing a benchmarking system as an evaluative tool.

Magellan. In 2004, Magellan contracted with Polaris Health Directions to provide assessment tools for an outcomes measurement and reporting system, Outcomes360. Polaris is an outcomes management company that has developed clinical assessment tools that use self-reporting of symptoms, functioning, and strengths. The program was implemented in Bucks County with four major providers participating. According to Magellan, providers have said that they find the assessments and subsequent reports useful and have been able to achieve almost 100 percent participation by patients.

Using the Child and Adolescent Needs and Strengths (CANS) assessment, among other tools, patients complete self-assessments in the provider's office. Reports based on these assessments are generated for the clinician's use in planning and monitoring treatment. Reports include information and scores for overall behavioral health status, symptoms, and functioning, with detailed depression and anxiety scores, treatment history, and member strengths as well as high-risk indicators.

Both Magellan and the participating providers are using the data to assess outcomes for their clients. The system allows providers to get a clinical picture of a youth over time, using the data collected from assessment instruments that measure symptoms, functions, and strengths. In addition, Magellan reviews process data elements such as length-of-stay, cost of treatment, and drop-out rates. The data from individuals' reassessments have already resulted in some system change, for example, providing more after care services.

Community Behavioral Health Network of Pennsylvania (CBHNP). CBHNP has contracted with the University of Maryland's Children's Outcomes Management Center to develop and implement an outcomes measurement system for its network members. The system, called Kidnet, has only been implemented for one year. The system uses standardized assessment tools, CAFAS and CANS among them, that are answered by the client, parents, and other persons who are important in the child's life, such as teachers, to gain a detailed understanding of a child's mental health status. A child is assessed at three month intervals.

The system has four ways to evaluate outcomes: (1) the system can track the individual patient to determine what progress is being made over time; (2) it helps clinicians in treatment planning and allows them to make more targeted changes to treatment plans; (3) provider agencies can use current data to assess the effectiveness of its programs; and (4) the system allows review of data of evidence-based treatments. Currently, the system is in use for children receiving BHRS and family-based services, and CBHNP intends to expand its capabilities to evaluate other residential and outpatient services. The system has not been in place long enough to produce usable results; CBHNP expects to be able to utilize the system's data by fall 2006.

Provider Association Benchmarking Initiative. As of May 2006, the Pennsylvania Community Providers Association (PCPA) was developing a behavioral healthcare benchmarking system in collaboration with OMHSAS and Behavioral Pathway Systems intended to:

- analyze the performance of aggregate groups of service providers using indicators such as client outcomes, client safety, care management, fiscal health, etc.;
- enable providers to improve their performance based on the application of benchmarking principles and practices; and
- provide a comparative basis to improve the overall effectiveness of Pennsylvania's services for those who have mental retardation, mental health issues, and addictive diseases.

PCPA believes that there is not sufficient capability to identify the practices and procedures that produce the best system performance, contribute to the financial viability of providers or the delivery system as a whole, and enable providers to hire and retain competent staff. Additionally, behavioral healthcare organizations do not have sufficient capability to select and implement the best practices, partially because of the limited availability of outcomes and performance measurement. According to PCPA, this initiative will allow organizations to track their performance over time, in part by measuring a particular organization's performance against state and national norms. Seventy-five PCPA member organizations are participating in the program's initial stages.

Increasing Recognition of the Value of Evidence-Based Approaches

Evidence-based treatments are those that have been proven to have a positive benefit. This approach has been receiving more widespread support among researchers and clinicians in the past two decades.[5] Because there is little evidence that many treatments that are currently in use have positive outcomes, evidence-based is also receiving more attention at the state level. To be evidence-based, a treatment modality must meet five criteria:

- the technique has well defined treatment procedures that can be taught to other therapists;
- evaluation of the technique uses well controlled studies;
- clear definition of the selection criteria for treatment participants in the study;
- use of multiple outcome measures; and
- results can be replicated in multiple settings.

Use of Evidence-Based Programs

A recent study[6] using a sample of youths registered within the Child and Adolescent Mental Health Division (CAMHD) of the Hawaii Department of Health evaluated the extent to which evidence-based services provide coverage for youths seeking intensive services through the CAMHD. The study, using a sample of 2,197 youths, found that:

- 33 percent had a single diagnosis for which an evidence-based service was identified,
- 89 percent had a primary diagnosis with a relevant evidence-based service, and

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[5] Kettlewell, PW et al. *Evidence-Based Treatment: What It Is and How It Can Help Children,* Pennsylvania CASSP Training and Technical Assistance Institute, Penn State University, 2005.

[6] Schiffman, J. et al. "Evidence-Based Services in a Statewide Public Mental Health System: Do the Services Fit the Problems?," *Journal of Clinical Child and Adolescent Psychology,* 2006, Vol. 35, No. 1, 13-19.

- 90 percent (based on the 1,220 youths with treatment target information) had one or more problem areas targeted for intervention with an identified evidence-based service.

The study also identified youths with problems for which no evidence-based treatment was identified. This study's findings generally show that many of the juveniles receiving services appear to be well suited to receive evidence-based services.

Cost Benefit Analysis

The Washington State Institute for Public Policy, reporting to the Legislature, has performed an in-depth cost-benefit analysis of various treatment programs. Different types of programs were evaluated, including those in juvenile justice, education, and welfare. Benefits included those that go to the participant, for example, students graduating from high school and increasing earnings; those that go to non-participants, such as taxes on increased earnings; and those that reduce crime and crime victimization. The study found that "certain well-implemented programs can achieve significantly more benefits than costs." Table 4 below shows some of the programs that were evaluated, including some of those in use in Pennsylvania, and the associated benefits and costs. It concludes that some treatments, such as Functional Family Therapy and Multidimensional Treatment Foster Care, are highly cost effective, while others have higher costs than benefits.

Table 4

Benefits and Costs of Selected Programs

Program	Benefits	Costs	Benefits Minus Costs
Functional Family Therapy	$28,356	$2,140	$26,216
Juvenile Intensive Probation Programs	0	1,482	(1,482)
Multidimensional Treatment Foster Care	27,748	2,459	24,290
Multisystemic Therapy	14,996	5,681	9,316
Regular Parole	(10,379)	2,098	(12,478)
Systems of Care/Wraparound Programs	0	1,914	(1,914)

Source: Washington State Institute for Public Policy report, *Benefits and Costs of Prevention and Early Intervention Programs for Youth,* September 17, 2004.

Pennsylvania Is Addressing Lack of Outcomes Through Evidence-Based Practices

DPW is encouraging providers to use evidence-based practices and has recently allowed for evidence-based treatments (see Functional Family Therapy and Multisystemic Therapy above) to be eligible for payment by Medical Assistance. In addition, DPW has also encouraged providers to submit service descriptions for

Multidimensional Treatment Foster Care, another evidence-based treatment program.

The Department does, however, recognize that initiating evidence-based practices can be expensive for a provider due to training costs, small initial client loads, and initial delays in reimbursement. To address this, the Pennsylvania Commission on Crime and Delinquency has provided seed money in the form of grants (see Chapter III.A) to many providers throughout the state to begin using evidence-based practices. Also, according to a Department official, various foundations have contributed to start-up costs, in addition to some agencies providing their own funds.

DPW also applied for a Substance Abuse and Mental Health Administration (SAMHSA) grant to develop evidence-based treatments within the children's mental health system in Pennsylvania. The three aims of this grant proposal were (1) to form an infrastructure to implement more evidence-based practices in Pennsylvania through a State Advisory Board on Children's Services, (2) conduct an assessment of current practices and use of evidence-based practices, and (3) create awareness and support for the implementation of evidence-based practices. The Department did not receive the grant, but continues to encourage evidence-based practices. Relatedly, the *Third Biennial Research to Practice Forum: A Symposium on the State of Promising and Evidence-Based Practice in Children's Services in Pennsylvania* was held at Penn State University in March 2006. During this conference, an OMHSAS official recognized the value of evidence-based programs and discussed why these modalities are not more often utilized, including lack of awareness; funding streams, policy, and regulations that are unsupportive; strength of the status quo; and reluctance to adopt new practices, among others. The official reported that DPW believes that evidence-based practices are not the only answer, but part of an overall strategy to provide more effective services.

The Department of Education has also recognized the need for mental health treatment programs that are based on proven outcome measures. The Department currently has a pilot program, Response to Intervention (RTI) that incorporates evidence-based results measurement principles. This program is a comprehensive, multi-tiered intervention strategy designed to enable early identification and intervention for students at academic or behavioral risk. RTI uses a scientifically based approach for evaluating outcomes for students and uses rigorous, systematic, and empirical methods to determine successful results. RTI requires research-based core curriculum for reading and math and requires proven effective instructional practices for all students.

Instead of requiring students to experience failure before being considered for special education services, Response to Intervention attempts to identify learning disabilities at an early stage. This is accomplished by school-wide screening of academics and behavior for all students in the regular education setting. The three-tiered RTI system provides monitoring and adaptations or mild interventions within the regular school setting for students identified as Tier 1. Tier 2 involves selected interventions as indicated for "at risk" students, and Tier 3 provides specialized, more intensive interventions or treatment placements.

The Governor's Commission for Children and Families also issued recommendations as part of its March 2006 report for increased use of evidence-based practices. The Commission recognized that there are inadequate resources to support proven or promising practices, and too often programs that seem to be showing good outcomes lack funding. The report states that children and their families should receive the most effective care and that public funds should not be spent on ineffective services.

To that end, the Commission recommendations include: identifying programs that work and do not work and reallocating funds to those that do; expand MA reimbursement for evidence-based programs; expand training and technical assistance to transfer the knowledge of proven programs to the counties; and expand funding and increase efforts to turn promising programs into proven programs.

National Registry of Evidence-Based Programs and Practices

National Clearinghouse Resources for Evidence-Based Programs. SAMHSA includes on its website a listing of model programs that have been reviewed by its National Registry of Evidence-Based Programs and Practices. The listed programs are in one of three categories:

- *Promising Programs*: These programs have been implemented and evaluated sufficiently and are considered to be scientifically defensible. They have shown positive outcomes, however, they have not yet been shown to have sufficient rigor and/or consistently positive outcomes required for effective program status.
- *Effective Programs*: These programs are well-implemented, well-evaluated programs that produce a consistent positive pattern of results. They meet the same criteria as model programs with one exception: their developers have yet to agree to work with SAMHSA to support broad-based dissemination of their programs but may disseminate their programs themselves.
- *Model Programs*: These programs are well-implemented, well-evaluated programs, meaning they have been reviewed by the National Registry of Evidence-based Programs and Practices (NREPP) according to rigorous standards of research. Developers have coordinated and agreed with SAMHSA to provide quality materials, training, and technical assistance for nationwide implementation.

Evidence-Based Blueprint Programs

The Center for the Study of Prevention of Violence at the University of Colorado implemented a national violence prevention initiative to identify programs that are effective. The program, Blueprints for Violence Prevention Initiative, has identified 12 model prevention and intervention programs, called Blueprints. These programs have been successful in reducing adolescent crime, aggression, delinquency, and substance abuse. There are also 14 promising programs. Appendix F details the Blueprint programs as well as some of the model programs listed on SAMHSA's website.

Evidence-Based Programs in Pennsylvania

Two evidence-based practices became eligible for MA payment in Pennsylvania in 2005: Family Functional Therapy and Multisystemic Therapy. Both are Blueprint programs.

Functional Family Therapy. Functional family therapy (FFT) is a research-based prevention and intervention program for at-risk adolescents and their families that targets youth between the ages of 11 and 18. It is a short-term family-based program that can be used for a range of adolescent problems, including violence, drug abuse, conduct disorder, and family conflict.

FFT services can be delivered in a variety of settings. For example, it is used for runaway or truant youth in Seattle; in housing authorities in Chester, Pennsylvania; as an alternate to detention for first time misdemeanors in Miami; and in family drug court in Oregon. FFT has been implemented in over 150 sites and has been widely evaluated in local communities.

Multisystemic Therapy (MST).[7] This therapy is an intensive family and community based therapy that targets chronic violent or substance abusing juvenile offenders at high risk of out-of-home placement. It is provided using a home-based model of service delivery, and duration of treatment is about four months. The major goal of MST is to enable parents to address the issues of their child and to empower youth to cope with family, peer, school, and neighborhood problems. Other goals include reducing criminal activity, reducing other types of antisocial behavior, and achieving these outcomes at a cost savings.

MST differs from other family-based treatment models in four ways: it emphasizes factors in the adolescent and family's social networks that are linked with antisocial behavior; it has programs with a strong commitment to removing barriers to access to services; its intensity of treatment is greater than other family-based therapies; and there are well-documented, long-term outcomes.

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[7] Information in this section is from the Multisystemic Therapy Services website.

Sharing of Evidence-Based and Promising Practices

A concept paper developed by the Juvenile Law Center and submitted to DPW and pertinent stakeholders in April 2006 proposes that Pennsylvania establish a center for the dissemination and support of evidence-based treatment programs for youth who are involved in or at risk of becoming involved in the juvenile justice system. The main function of the center, modeled in part after an Ohio initiative,[8] would be to provide training and clinical and supervisory support to providers to help them develop and sustain evidence-based practices. The concept paper proposes that the center would:

- coordinate the expansion and provision of evidence-based practices with state and county agencies;
- identify funding streams that could be redirected to evidence-based programs;
- assess site readiness for new Blueprint projects; and
- evaluate evidence-based practices by collecting state-wide performance data and measuring outcomes.

As of May 2006, DPW was reviewing and considering the proposal.

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[8] The Center for Innovative Practices is supported by the Ohio Department of Mental Health and the Stark County Community Mental Health Board. Its mission is to increase access to and availability of evidence-based and best practice mental health interventions for youth and their families.

III.C. Screening and Assessment Instruments for Children With Behavioral Health Issues Are Not Standardized

Methods for screening and assessing youth for mental health related issues are not standardized throughout Commonwealth agencies and counties, creating inconsistencies in how youth are screened and/or assessed for possible mental health issues. Several initiatives are now underway to improve and standardize these instruments.

MacArthur Foundation Activities and Support in Pennsylvania

Models for Change Initiative

In August 2004, the John D. and Catherine T. MacArthur Foundation awarded Chester, Erie and Allegheny counties each a grant for $150,000 ($50,000 a year for three years) to hire mental health/juvenile justice coordinators as part of the Foundation's Models for Change Initiative. These counties are to serve as "model" counties for the mental health/juvenile justice initiative in Pennsylvania.

In February 2005, a strategic planning workshop was held with representatives from the three grant-receiving counties, as well as a statewide team. The Models for Change Initiative was the specific strategic planning model used, and the workshop resulted in goals in two major areas:

- The development of a statewide screening and assessment process.
- The development of a continuum of services for children in the juvenile justice system who are experiencing mental health problems.

To address the goal of developing a statewide screening/assessment process, the Research Committee of the Pennsylvania Council of Chief Juvenile Probation Officers was asked to review potential screening and assessment tools to determine those most appropriate for use by the Pennsylvania county juvenile probation departments. This group identified and endorsed six specific screening and assessment tools for possible use by juvenile probation departments. These six screening and assessment tools are described below.

Screening and Assessment Initiatives Through the MacArthur Foundation

Pennsylvania was the first state to be selected to participate in the MacArthur Foundation Models for Change Initiative.[1] The initiative awards grants to develop, support, and distribute "best practices" throughout the U.S. A key component of this project is enhancing mental health services for youth and adolescents who have become engaged in the juvenile justice system.

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[1] Washington, Louisiana, and Illinois are the other states selected.

The Juvenile Law Center was designated as the Foundation-funded organization to lead the Models for Change Team. The Foundation is providing at least $7.5 million in funding to organizations in Pennsylvania through 2008 to build upon the reforms already underway. The initiative is focusing on three main areas, one of which is Mental Health/Juvenile Justice Coordination.[2] The goal of the initiative in this area is to improve the coordination of and access to mental health services for court–involved young people in Pennsylvania. A key activity of this initiative is improving screening and assessment measures. A subcommittee was established to further the screening/assessment objective.

Screening and Assessment Subcommittee Activities. In January 2006, the Juvenile Court Judges' Commission (JCJC) hosted a screening and assessment training for county chief juvenile probation officers and their staff. The training provided information on the specific screening and assessment instruments that were endorsed for the project. The following screening/assessment tools were examined (see also Exhibit 5 for further explanation of the function and differences of screening and assessment tools):

- **Massachusetts Youth Screening Instrument-Second Version (MAYSI-2).** The MAYSI-2 is a brief screening tool designed to assist juvenile justice facilities in identifying youths 12 to 17 years old who may have special mental health needs. It is intended for use at any entry or transitional placement point in the juvenile justice system (e.g., intake probation, pretrial detention, and state youth authority reception centers). The MAYSI-2 can be administered routinely to all youths in probation intake interviews or within 24 to 48 hours after their admission to juvenile justice facilities. It requires no more than 15 minutes to administer and does not require the expertise of a mental health professional for scoring and interpretation.
- **Problem Oriented Screening Instrument for Teenagers (POSIT).** The POSIT is a self-administered instrument that measures 10 problem areas, including mental health and substance abuse. The POSIT includes information on the history of juvenile justice and mental health contacts, health care utilization, and current stressors. It is designed to quickly identify problems in areas requiring further assessment.
- **Youth Level of Service (YLS).** The YLS is designed to survey attributes of offenders and their situations in order to select an appropriate level of supervision and make treatment decisions. Probation officers, parole officers, and/or correctional workers interview youth and review file data, test scores, and other data. These ratings provide comprehensive risk/needs assessment important for offender treatment planning.
- **Child and Adolescent Needs and Strengths (CANS).** An assessment tool that can be administered in the form of an interview, a series of interviews, a child and family planning team meeting, or a record review. CANS can be used by probation officers, child welfare caseworkers, parent liaisons, and mental health workers.

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[2] Other areas include aftercare and disproportionate minority contact (See Appendix G).

- **Intervention Needs and Competency Assessment (INCA).** The INCA is a structured screening interview designed to assess risk to the community and need for intervention by examining competencies and problems in the following areas: legal, family relationships, education, work, psychological and social adjustment, drug and alcohol use, personal relationships, and demographics.
- **Washington State Juvenile Court Assessment (WSJCA).** The WSJCA is a 132 item, two stage assessment designed to determine if a juvenile offender is at a high risk to re-offend. The first stage is a pre-screen assessment that is administered to all youth on probation, usually during intake when routine criminal and social history data are collected. The pre-screen produces scores for criminal and social history and generates either a low, moderate, or high risk level for re-offending. The second stage of the assessment is completed if the juvenile offender scored either moderate or high on the pre-screen assessment. This stage includes an interview with the youth and the family with a juvenile probation counselor who interprets information received to complete the full assessment using professional judgment and training.

Following the review of these selected instruments, the chief juvenile probation officers were asked to confer with their local juvenile court administrative judge, district attorney, public defender, mental health/mental retardation administrator, and others involved with the system about participating in a pilot program to create a screening and assessment process in their jurisdictions. The goal of this effort is to move toward a standard method of screening and assessment that can be used throughout all systems that interact with youth.

Exhibit 5

Comparison of Screening and Assessment Tools

Screenings are simple, brief, and generally administered by non-clinical staff. They require little training with decisions to refer youth to further evaluations generally determined by agency policy and not on the recommendation of the clinician. Screenings are seen as an effective and quick tool for identifying youth with mental health disorders who are in need of immediate attention. Screening is not meant to provide an accurate psychiatric diagnosis, but to identify exceptionally troubled youth for which some special and immediate response is necessary.

Assessments are generally comprehensive evaluations that are intended to identify service needs. Comprehensive assessments will usually identify concerns that were overlooked during a mental health screening. A comprehensive assessment should include information from as many sources as possible. An assessment should consist of direct observation and face-to-face interviews with the youth, a mental status examination, chart review, interviews with parents/other adults, and family history. Assessments are most useful when the information they provide is both comprehensive and accurate. The use of scientifically sound assessment tools helps to assure that high quality information is obtained. A mental health assessment often can require the expertise of a mental health professional.

Source: Developed by LB&FC staff from literature.

Timing of Screening and Assessment Tools. A related issue concerning the administration of screening and assessment for mental health problems is when to conduct the screenings/assessments. The Screening and Assessment Subcommittee has recommended that screening/assessment be conducted as soon as possible to aid in identifying youth with mental health needs.

The majority of counties indicate that they will administer their screening/ assessment for mental health issues during the intake phase of the process. Other counties noted that screening/assessments would be conducted post-adjudication, before and following the disposition, and during the aftercare phase.

Erie County has already had the opportunity to address this issue because of their involvement with the initial MacArthur pilot project. The Erie County Mental Health & Juvenile Services Flowchart (Appendix H) describes the screening/ assessment process once a youth enters a shelter or detention center. Youth entering the system will be administered the MAYSI-2 (screening tool) within 24-48 hours and may receive a subsequent assessment, such as INCA or ASAM (assessment tools), depending on the score received on the initial MAYSI-2 screening instrument and other factors.

Mental Health Assessment of Youth in Detention Project

The Juvenile Detention Centers Association of Pennsylvania (JDCAP) has overseen the implementation of the MAYSI-2 in secure detention centers since 2000. This has been one of the main efforts of the Mental Health Assessment of Youth in Detention Project, which is grant funded through the Pennsylvania Commission on Crime and Delinquency (PCCD). Between August 2001 and February 2005, the MAYSI-2 was administered 30,678 times in twenty participating detention centers. Data from the MAYSI-2 administrations has been collected, and the project is currently in its final phase, which consists of project evaluation by a co-developer of the MAYSI-2. The widespread use of the MAYSI-2 in the juvenile detention centers (currently 22 out of 23 centers are using the MAYSI-2) will allow the development of a standard and reliable database that contains juvenile justice and mental health data on youth detained in detention centers.

The research generated from this project shows that 77 percent of youth who enter Pennsylvania's detention centers present some form of mental health issue. Approximately 70 percent of males and 81 percent of females scored above the clinical cut-off for at least one of the five MAYSI-2 scales: Alcohol/Drug Use; Angry-Irritable; Depressed-Anxious; Somatic Complaints; and/or Suicide. The JDCAP will continue to use information collected from the MAYSI-2 in various ways, including: examining the relationship between MAYSI-2 scores and committing offenses of the youth; possibility of predicting behavior patterns of youth in detention by the

MAYSI-2 scores, determining the length of stay in relation to the MAYSI-2 score, and determining the release locations based on MAYSI-2 scores.

Department of Public Welfare Screening and Assessment Pilot Projects

Beginning in 2004, the Department of Public Welfare, through the Office of Children, Youth and Families (OCYF) and the Office of Mental Health and Substance Abuse Services (OMHSAS) provided $1.2 million to fund four pilot projects to conduct screenings and assessments for behavioral health issues of youth in the juvenile justice system. A criterion for selection to be a pilot county was the use of the MAYSI-2 assessment tool. The four pilot counties are Allegheny, Bucks, Chester, and Erie.

The pilot's aim is to create consistency in evaluating the youth in the child welfare or juvenile justice systems who may have a mental health or substance abuse disorder. Each county has a local team involving the mental health, juvenile justice, courts, and child welfare system that oversees the implementation of the pilot project.

A study of these four pilot projects was conducted by researchers at the University of Pittsburgh. Their report suggests, however, that the findings are inconclusive and require further study. The general lack of data and poor response rates to the study were the main issues raised by the report. One of the unanticipated problems that researchers encountered was the concern for 5th Amendment rights against self incrimination (see below).

Additionally, the report highlights the need for interagency cooperation. Competing/conflicting goals of the various agencies and organizations raise issues concerning which factors will most influence placement and treatment decisions. The report recommends that more care needs to be taken in the development and implementation phases to find common ground between research and practice.

Governor's Commission for Children and Families

The Governor's Commission for Children and Families has also found that children who have parents that are experiencing behavioral health problems are not being properly screened or treated in a preventative manner for mental health issues. The Governor's Commission proposed a uniform or standardized screening/ assessment for such children, noting that a high percentage of children in the mental health system also have parents with emotional and mental health problems. Specifically, they recommend that the behavioral health system (OMHSAS and Department of Health) should make available uniform screening/assessment of the children of parents in treatment and effectively link the children with indicated preventative interventions.

Variability and Inconsistency of Juvenile Mental Health Screening or Assessment at the County Level

A JCJC survey of county juvenile justice offices prior to the January 2006 screening and assessment conference found that approximately half of the counties were not performing any type of screening or assessment for youth entering the juvenile justice system. The other half used various types of screening/assessment tools, which were not coordinated by any overall plan or agency.

The efforts of the MacArthur Project Screening/Assessment Subcommittee are intended to solve these issues and others. The intent is to have the pilot counties provide screening/assessments to youth in the juvenile justice system by the end of 2006. However, funding for the pilot counties must be located (funds will be requested from the MacArthur Foundation), two of the screening/assessment tools still require additional work, and decisions need to be made concerning implementation, data collection, and organization.

One issue that has yet to be resolved is whether the Screening/Assessment Subcommittee will recommend a single, multisystem screening and assessment instrument for the pilot counties. Unless one of the instruments is far superior to the others, counties may be reluctant to use a new instrument, especially if it requires retraining, additional computer programs, and additional funds to facilitate the change. Additionally, some screening/assessment tools are designed for use in specific systems and on specific populations, such as juvenile offenders, so achieving multisystem acceptance of a single screening/assessment tool may be difficult.

In the event that multiple screening/assessment tools remain in use following the completion of the pilot process, the possibility of cross-walking the tools is a potential solution. This would require standardizing the results of the screening/ assessment tools so that results obtained from one tool are similar to those obtained from another tool. The HealthChoices Managed Care Organization in south central Pennsylvania, CBHNP, (along with researchers at the University of Maryland) is working to develop such a crosswalk between CANS and the Child and Adolescent Functional Assessment Scale (CAFAS), both of which are widely used assessment tools. The result would be the ability to use the information obtained from either CANS or CAFAS and reliably apply it to the other assessment tool. This would enable appropriate treatment decisions to be made regardless of what assessment tool was utilized.

Self-Incrimination Has Also Been Noted as an Issue That Must Be Resolved for Statewide Screening and Assessments for Mental Health

Pennsylvania law does not currently provide specific protections for juveniles who may make self-incriminating statements while undergoing screening or assessment for behavioral health problems. Although the Juvenile Act prohibits the use of incriminating statements made to a person providing counsel or advice as part of an informal adjustment prior to the filing of a petition from being used in any criminal proceeding or a proceeding under the Juvenile Act,[3] it does not include mental health evaluations and assessments that may be made in other contexts. Other states specifically provide for these protections.

Allegheny County's effort to implement an assessment tool has met with resistance from the Allegheny County Public Defenders Office due to its concern about self-incrimination. Allegheny County's Department of Human Services noted that the public defender objected to any type of screening of juvenile offenders. Similar legal concerns were also expressed during the participant recruitment phase of the DPW screening and assessment demonstration project conducted by researchers at the University of Pittsburgh. The researchers noted that county officials raised legal concerns related to the ambiguity surrounding the confidentiality of information obtained during the assessments. The project report suggests that participation was severely hampered by this concern.

Chester County has successfully used a memorandum of understanding (MOU) between the district attorney and the public defender to address this concern. However, previous efforts to establish the use of a screening/assessment tool in the juvenile court system in Chester County ended due to a disagreement over the self-incrimination issue.

The Juvenile Law Center reviewed other states' statutes to identify provisions that might be useful to incorporate in an amendment to the Juvenile Act as part of its participation in the MacArthur-funded project in Pennsylvania. Their analysis highlighted several states' provisions including the following:

- *Maryland*. Information or statements secured during a §3-A8-17 study,[4] which includes court-ordered mental health evaluations of the minor, is not admissible in evidence in any adjudicatory hearing or peace order proceeding "except on the issue of respondent's competence to participate in the proceedings and responsibility for his conduct . . . where a petition alleging delinquency has been filed, or in a criminal proceeding prior to conviction." This section further provides that

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[3] Persons providing counsel and advice include social service agencies, probation officers, and other officers of the court.

[4] Section 3-8A-17 covers court-ordered studies of the child, the child's family, or the child's environment, including examinations by mental health professionals. This section further provides that reports of these studies are admissible as evidence at waiver and disposition hearings but not at an adjudicatory hearing.

"the report of a study under this section is admissible as evidence at a waiver hearing and at a disposition hearing, but not at an adjudicatory hearing." Information obtained during intake procedures is also protected from use in an adjudicatory hearing or peace order proceeding subject to the same exception discussed above.

- *Missouri*. Any time after a petition has been filed the court may order a juvenile to be examined by a physician, psychiatrist or psychologist appointed by the court to aid in determining the child's mental health. Where the examination is made prior to the adjudicatory phase of the hearing, in a case where the petition alleges a violation of state law or municipal ordinance, the juvenile has a right not to incriminate himself. This is similar to the protections provided to adults under other sections of law. Further, after a child is taken into custody, all admissions, confessions, and statements by the child to the juvenile officer and juvenile court personnel (e.g., physicians, psychiatrists, psychologist, and all evidence given in cases under this chapter) as well as all reports and records of the juvenile court, are not lawful or proper evidence against the child and shall not be used for any purpose whatsoever in any civil or criminal proceeding.
- *Texas*. The Texas Human Resources Code provides for the mental health screening of juveniles who have been referred to the probation department. Any statement made by a child as well as any mental health data obtained from the child during the administration of the mental health instrument is not admissible against the child "at any other hearing."
- *West Virginia*. The court, upon its own motion or upon request of counsel, may order a psychological examination of the juvenile. The report of the examination, however, is not available to the court until after the adjudicatory hearing.
- *Connecticut*. The state's statute with respect to juvenile matters provides that any information concerning a child that is obtained during any mental health screening or assessment of such child shall be used solely for planning and treatment purposes and shall otherwise be confidential and retained in the files of the entity performing such screening or assessment. This information may be further disclosed only for the purposes of any court-ordered evaluation or treatment of the child or provision of services to the child, or pursuant to laws mandating reporting of child abuse or elder abuse. The information is not subject to subpoena or other court process for use in any other proceeding or for any other purpose.

As of May 2006, the Juvenile Law Center was in the process of drafting language that could result in an amendment to the Juvenile Act to provide protection from self-incrimination in the screening, assessment, and treatment process. The Center was sharing draft language with various stakeholders and building a consensus for specific statutory language. They expected to complete this in the next few months and plan to include it in the MacArthur screening and assessment subcommittee proposed recommendation.

Counsel with the Juvenile Law Center has also been asked by the Mental Health/Juvenile Justice work group (MacArthur Foundation Models for Change Initiative) to establish an independent legal protections subcommittee, which will further examine the issues of self-incrimination and information-sharing.

IV. Cost and Timeliness of Mental Health Services for Children and Youth

A. The Cost to Address Children's Mental Health Needs Has Trended From $750 Million to Over $1.0 Billion Annually in Recent Years and Is Primarily a Public (Medical Assistance) Payer System

While we were not able to determine the total cost of mental health services for children and adolescents in Pennsylvania, we were able to establish that public resources available to be used for this purpose currently exceed $1 billion annually. Of this total, DPW contributes $1.0 billion, PDE $ 31.1 million, and PCCD $3.3 million.

Private insurance has increasingly paid out more dollars for MH services, but nationally its percentage of the total expended for all ages has remained constant at about 22 percent. In Pennsylvania, this percentage is appreciably lower because of the MA "loophole eligibility waiver" (see Chapter IV.B).

The Commonwealth has several programs in place intended to control its costs, including: the Health Insurance Premium Payment program (HIPP), a data matching program to assure that MA is the payer of last resort, and a planned expansion of HealthChoices behavioral health managed care statewide.

Cost Estimates and Trends

Nationally, MH expenditures for all persons grew annually at an average rate of 5.7 percent from 1991 to 2001; slightly slower than the 6.5 percent growth rate experienced by all health care spending over that time period. SAMHSA estimates that $85 billion, or about 6.2 percent of all health care spending, was expended nationwide to treat mental disorders in 2001.[1] Contributing to the growth in mental health spending has been an increase in the number of people receiving services, increases in medication prices, more people using psychotropic medications, and increases to the labor costs of those providing services.

SAMHSA also reports that 45 percent of all health care funding in 2001 came from public sources and that the majority of the funds for mental health services, 63 percent, were from public sources. Among public payers, Medicaid is the

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[1] Mark TL, Coffey RM, McKusick DR, Harwood H, King E, Bouchery E, Genuardi J, Vandivort R, Buck J, Dilonardo J. *National Estimates of Expenditures for Mental Health Services and Substance Abuse Treatment 1991 – 2001,* SAMHSA Publication No. SMA-05-3999, Rockville, MD, Substance Abuse and Mental Health Services Administration, 2005.

largest source of funding nationwide, contributing 27 percent of total MH funding in 2001 and 44 percent of all public source MH funding.

Pennsylvania's Medical Assistance enrollments increased from about 1.7 million in 2004 to over 1.8 million in 2005. From 2004 to 2005, the number of children and adolescent MA eligibles in Pennsylvania increased from 815,687 to 856,960. The number of children less than 18 years of age using MH services paid for by MA in Pennsylvania in 2003 was just less than 100,000, or about 12 percent of the children eligible for Medical Assistance.

Rand Health estimated that the cost of treating children and adolescents (ages 1-17) for behavior disorders and emotional disturbances was $11.7 billion nationwide in 1998 dollars. More than half of this cost ($6.9 billion) was for the treatment of adolescents (ages 12–17). A straight line projection of these expenditures using the growth rate from 1991–2001 brings the nationwide behavioral health total for treating children and adolescents to $17.2 billion by 2005. In FY 2004-05, expenditures through Pennsylvania's HealthChoices and Fee-for-Service programs alone were almost $930 million for child and adolescent behavioral health care. In 2003, adolescents aged 13–17 accounted for 40 percent of the Commonwealth's children's MA mental health expenditures.

Public Resources Available in Pennsylvania to Pay for MH Services

Department of Public Welfare

DPW's OMHSAS funds the county mental health offices and their associated programs and collects data on actual expenditures for mental health services (MA reimburses for most of the treatment provided). As of early 2006, DPW was migrating its data to a new system, but the conversion has been slow. As a result, we were able to obtain only one complete year of encounter data. DPW's OCYF funds county child welfare and juvenile justice programs (many of which have a mental health component). OCYF does not, however, track county expenditures in a manner that separates the MH costs from all others and was hesitant to estimate a percentage of total expenditures to attribute to MH.

Although we were unable to establish the actual total cost for children's mental health services, we worked with the various Commonwealth agencies to estimate the public resources each apply toward children's mental health. Table 5 displays the results.

Table 5

Commonwealth Financial Resources Funding Children's and Adolescent Mental Health Services

(Estimated)

	FY 2004-05	FY 2003-04	FY 2002-03	FY 2001–02
Department of Public Welfare				
OMHSAS[a]				
HealthChoices	$ 583,106,184	$ 575,844,848	$554,979,933	$459,811,767
Fee-for-Service[b]	346,580,781	330,076,934	314,358,985	369,387,296
MH Base	78,679,481	74,932,839	74,037,078	53,623,568
Subtotal	$1,008,366,446	$ 980,854,621	$943,375,996	$882,822,631
OCYF[c]	NA	NA	NA	NA
Department of Education				
Safe and Drug-Free Schools and Communities Program (SAP)[d]	$ 11,082,863	$ 6,659,686	$ 5,985,914	Not Collected
Alternative Education	20,060,364	20,652,666	26,256,000	Not Collected
Subtotal	$ 31,143,227	$ 27,312,352	$ 32,241,914	$ 0
PA Commission on Crime and Delinquency				
Functional Family Therapy, Multisys temic Therapy, Multidimensional Treatment Foster Care, and Brief Strategic Family Therapy	$ 2,222,914	$ 2,454,119	$ 2,818,436	$ 1,951,534
Student Assessment Project	1,125,000	1,125,000	1,125,000	1,125,000
Subtotal	$ 3,347,914	$ 3,579,119	$ 3,943,436	$ 3,076,534
Total All Sources[e]	$1,042,857,587	$1,011,746,092	$979,561,346	$885,899,165

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[a] All behavioral health (including autism). FY 2003-04 Fee-for-Service and FY 2004-05 HealthChoices, Fee-for-Service and MH Base estimated; all others are actual expenditures.

[b] Through FY 2005-06, these services were administered by the Office of Medical Assistance Programs (OMAP).

[c] Integrated Children's Services Initiative budgeted $75.1 million in child welfare/juvenile justice expenditures to transition to MA, with a potential of an additional $28.6 million based upon county utilization.

[d] The Bureau of Drug and Alcohol in the Department of Health also receives $1.1 million annually for its Student Assistance Program coupled with the drug and alcohol block grant, a small portion of these activities are also related to mental health servicing of co-occurring diagnoses, and the continuum of behavioral health care.

[e] In addition counties utilize discretionary and matching funds. For example, Allegheny County estimates these funds at $778,412 for services provided to children.

Source: OMHSAS Children's Bureau, PCCD, and PDE. PCCD funds received on a federal fiscal year basis were distributed across appropriate state fiscal years. Grants awarded over more than one year were evenly distributed over the lifetime of the grant.

OMHSAS expenditures are actual for child and adolescent behavioral health services and have increased each of the past three years, but recent increases have been minimal. After a 38 percent increase in FY 2002-03, the MH base allocation increased at an average rate of 3 percent the past two years. During CY 2003, the

MA system paid out a total of $685,888,387 for mental health services provided to almost 100,000 children aged 0 to 17, or about $6,900 per child.

DPW's OCYF spent over a billion dollars for child welfare and juvenile justice programs. A percentage of this total pays for children's mental health services. As part of DPW's Medicaid realignment effort, $75 million of OCYF funding was identified in FY 2004-05 as being appropriate for MA funding, and an additional $28 million has been identified for possible conversion to MA through FY 2006-07, bringing the total to almost $104 million. (See Finding IV.C for additional information regarding medicaid realignment.) Children's MH expenses not transitioned to MA will continue to be funded from OCYF General Fund monies.

Department of Education and the Commission on Crime and Delinquency

Over the last three years, there has been, overall, a downward trend of education funds used for mental health services. PDE's alternative education resources declined almost $6 million from FY 2002-03 to FY 2003-04, but the grants for the Safe and Drug Free Schools and Communities Program increased by nearly $5 million from FY 2003-04 to FY 2004-05. PCCD monies that can be applied to mental health services also decreased; almost $600,000 less in FY 2004-05 than in FY 2002-03.

Mental Health Service Utilization by MA Recipient

According to DPW's HealthChoices and Fee-for-Service data, outpatient clinics saw the greatest number of children of the eleven mental health service categories in Table 6. The most dollars expended, over $239 million of the $530 million paid by HealthChoices and almost $143 million of the $255 million paid through Fee-for-Service, were for BHRS (wraparound services). The dollars expended and the units of service delivered were 8–10 times greater than those in the second highest category, partial hospitalization. Not unexpectedly, the highest average expenditure per unit of service was for inpatient care in both delivery systems ($494 and $573 per day respectively). See also Appendices I and J for HealthChoices and Fee-for-Service expenditures by county for these service categories.

CHIP – Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) provides both free and subsidized health care services in accordance with the Children's Health Care Act, Act 1998-68, 40 P.S. §§991.2301 et seq. Ninety-three to 95 percent of CHIP recipients are in the free program. The Insurance Department currently has agreements with seven private-sector contractors to provide comprehensive health insurance for eligible children.

Table 6

Average MA Expenditures for Selected Mental Health Services

HealthChoices 2004

	Recipients	Quantity[a]	Paid	Average Cost Per Unit
Inpatient Psych Hospital (Not SMH)	5,763	90,204	$ 44,591,608	$494
Psychiatric Partial Hospitalization	6,924	2,038,293	30,868,255	15
Psychiatric Outpatient Clinic	51,919	982,430	29,259,498	30
BHRS[b]	23,979	22,852,800	239,496,830	10
Residential Treatment (JCAHO)	2,417	395,299	97,983,226	248
Residential Treatment (Non-JCAHO)	474	84,212	17,201,467	204
Clozapine and Clozapine Support	1,151	2,162	72,587	34
Crisis Intervention w/In-Home Capability	2,079	18,347	507,000	28
Family-Based MH Services	6,740	1,768,104	48,649,328	28
Targeted MH Case Management, Intensive Case Management, Resource Coordination	10,472	1,415,481	20,928,143	15
Other MH Services	1,196	204,866	913,329	4

Fee-for-Service 2003

	Recipients	Quantity[a]	Paid	Average Cost Per Unit
Inpatient Psych Hospital (Not SMH)	2,508	34,132	$ 19,566,309	$573
Psychiatric Partial Hospitalization	4,206	1,355,121	20,253,845	15
Psychiatric Outpatient Clinic	21,530	242,519	5,127,362	21
BHRS[b]	16,932	8,846,052	142,952,494	16
Residential Treatment (JCAHO)	1,214	244,482	57,845,819	237
Residential Treatment (Non-JCAHO)	75	7,936	1,140,363	144
Clozapine and Clozapine Support	8	5,854	15,002	3
Crisis Intervention w/In-Home Capability	2,804	25,366	276,885	11
Family-Based MH Services	1,638	360,606	5,215,643	14
Targeted MH Case Management, Intensive Case Management, Resource Coordination	3,273	372,647	2,549,615	7
Other MH Services	27	428	3,210	8

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[a] Service Units: Inpatient and RTF = day; Partial Hosp. = hour; Family-based MH = ½ hour; Targeted Case Management, Intensive Case Management, Resource Coordination, Crisis Intervention, and Clozapine = 15 minutes; Outpatient, BHRS, and Other MH units vary by specific service within the service category, e.g., outpatient psychotherapy can range from 30 to 75 minutes, psychological testing is hourly, and a diagnostic interview is by occurrence.

[b] Includes Mobile Therapy, Behavioral Specialists, and all of TSS. TSS is the majority of BHRS expenditures and this total includes group, school-based, and outcome-based TSS initiatives. DPW is unable to estimate the magnitude of these initiatives as a percent of total TSS dollars, but it believes the large majority of expenditures are for "traditional" TSS.

Source: Developed by LB&FC staff using service utilization data obtained from OMHSAS.

To be eligible for CHIP, a child must not be eligible for Medicaid or have any other health insurance, must be under the age of 19, must be a U.S. citizen or a lawful alien, and family income must fall within published guidelines that range from $19,600 for a family of one to $67,200 for a family of eight for the free program. Eligibility is lost if the child moves to another state, turns 19 years old, obtains private health insurance or is enrolled in Medicaid, becomes an inmate of a public institution or a patient in an institution for mental diseases, or provides misinformation at application that would have resulted in a determination of ineligibility had it been known. On average, 34 percent of cases that are terminated at the time of their annual renewal lose eligibility for CHIP because the child was determined to be eligible for Medicaid.

An analysis of the percent of program participants receiving behavioral health services when compared to commercial insurance and to Medicaid shows that the rates for CHIP are generally higher (see Table 7). The CHIP populations for these measures are small in comparison to the entire commercial and Medicaid populations, which may in part account for the variance in the overall percent of treatment utilization.

Table 7

Children's Behavioral Health Utilization

(Percent of Members Receiving Behavioral Health Services)

	Age	2001	2002	2003	2004	2005
CHIP	0 - 12	5%	6%	6%	6%	6%
	13 - 17	7	9	9	8	10
Commercial	0 - 12	3	3	3	4	4
Nationwide	13 - 17	7	7	7	8	8
Commercial	0 - 12	4	4	4	4	4
Regional	13 - 17	8	8	8	8	8
Medicaid	0 - 12	NC[a]	NC	NC	4	4
Nationwide	13 - 17	NC	NC	NC	9	8
Medicaid	0 - 12	NC	NC	NC	5	2
Regional	13 - 17	NC	NC	NC	12	5

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[a] NC = Not Collected.

Source: Department of Insurance.

According to Insurance Department officials, each of the CHIP contractors subcontract for behavioral health services, and the benefits array is very similar to what is offered by private insurance (for instance, Capital Blue Cross is a CHIP service provider in Dauphin County that subcontracts with Magellan for mental health services). CHIP does not require copayments, coinsurance, or deductibles; however, they do place service limits on inpatient MH services (90 days in combination with medical) and outpatient visits (50 a year). Typical MH benefits in CHIP include inpatient psychiatric hospital services and psychiatric outpatient clinic services, which includes psychiatrist, psychologist, and counseling services. The CHIP mental health benefit array does not presently cover any of the evidence-based programs discussed in Chapter III.B. DOI has not determined the budget impact of such a strategy.

Private Insurance Plans

Private insurance and out-of-pocket payers made up 43 percent of the estimated $49 billion spent in 1991 to treat mental disorders nationwide, but only 37 percent of the $85 billion spent in 2001 according to SAMHSA. Coverage of MH expenses by private insurance alone, however, remained reasonably constant during this ten-year period at 22 percent of total MH expenditures (about $19 billion in 2001) or about 4 percent of all health care spending covered by private insurance.

We found that, as might be expected, the utilization of children's mental health services in Pennsylvania differed quite a bit between MA and private insurance. As noted earlier, about 12 percent of Pennsylvania's MA eligible children utilized mental health services in 2003 within the public payer system; by contrast, the two private insurance plans that provided us with data reported the percent of their members less than 18 years of age receiving mental health services in 2004 at 2.5 percent and 4.3 percent.

Benefit Comparison

According to the parents, stakeholders, and DPW and county officials we interviewed, most private insurance plans offer a modest mental health benefit array when compared to what is offered by Medical Assistance. For example, services offered by the public system that private insurance does not offer include BHRS, crisis or emergency services, and family or community therapy.

In Pennsylvania, the current MA benefit package covers the following mental health services:

- Inpatient psychiatric hospitalization.
- Partial psychiatric hospitalization.
- Outpatient psychiatric services.
- Behavioral Health Rehabilitation Services (BHRS).
- Residential Treatment Facilities (accredited and non-accredited).
- Antipsychotic drug support.
- Crisis intervention with in-home capability.
- Family-based MH services.
- Targeted MH case management, intensive case management, resource coordination.

- Other MH Services, lab studies, plus various D&A services that would include co-occurring.

We attempted to determine what mental health services a "typical" private insurance would cover, but were informed by industry officials that this would vary greatly and would ultimately depend on what the consumer (employer) buys. SAMHSA researchers report that benefit design for employer-sponsored insurance is based on workforce characteristics (e.g., gender, age, type of profession) and is often specifically tailored to the group to be insured.

Reports by the Center for Mental Health Services indicate that inpatient and outpatient mental health treatment services are typically covered by employer-sponsored health insurance plans. However, the reports also note that there is a continuum of services between inpatient and outpatient care that can effectively treat many mental disorders and are often more cost-effective than inpatient care. These intermediate services include non-hospital residential services, partial hospitalization services, and intensive outpatient services, such as case management and psychosocial rehabilitation. Intermediate services such as these are covered by only about half of employer-sponsored health plans (see Table 8).

Table 8

Covered Intermediate Care Services by Type of Plan
(Percent of Private Plans Covering Each Type of Service)

	PPO	HMO	POS	Indemnity
Inpatient Psychiatric Care	96%	88%	95%	94%
Nonhospital Residential	52	50	56	51
Intensive Nonresidential	63	60	64	65
Outpatient Therapy	85	84	87	87
Crisis-Related Services	49	55	56	33

PPO – Preferred Provider Organization
HMO – Health Maintenance Organization
POS – Point of Service

Source: The National Survey of Employer-Sponsored Health Plans (Buck et al., 1999; William M. Mercer, Inc., 1999).

As can be seen from the table, barely half of the private insurance plans cover non-hospital residential service; intensive nonresidential services are covered by 60–65 percent of the plans, and the percentage of plans covering crisis-related services range from a low of 33 to a high of 56.

Effect of Limited Benefits by Private Insurance Plans

Most employer-sponsored health plans restrict coverage of MH insurance benefits to cap their financial liability. The plans use two basic types of maximum benefit limits: service limits that restrict the number of outpatient visits or inpatient days and dollar limits. Either limit may be annual or lifetime, but annual limits are the most common.

Maximum out-of-pocket expense limits are a way of protecting the consumer from catastrophic expenses. Certain mental health conditions require intensive treatment that is not completely covered by health plans. For example, in cases of serious mental illness such as schizophrenia, limited MH benefit packages often cover a person's first episode of treatment in a year, but not multiple episodes in a year. People with such treatment needs can incur catastrophic out-of-pocket expenses under these limited plans.

Officials from one private insurance company told us that access to services for children and adolescents is not as good as for adults because there are far fewer hospital beds/units and outpatient services that are trained to deal with children and adolescents. These officials further noted that there is a national shortage of MH services for children and adolescents. (See also Chapter III.A.) According to the officials, the net effect is that, even if the private insurance plans would cover an unlimited amount and scope of services, if the services are not available, there is not much the insurance plan can do.

Service utilization data shows the disparity that exists in the amount paid out per recipient between MA and private insurance. In CY 2003, for children less than 18 years of age, Medical Assistance paid almost $6,900 per child receiving mental health services. Using data provided by two private insurance plans, we calculated that these plans paid out $685 and $295 per person receiving services under the age of 18 in 2004. Limiting the comparison to just those service treatment categories covered in the private insurance data, the 2004 HealthChoices cost per recipient was $3,089 (2004 Fee-for-Service not available at time of analysis). Undoubtedly, several factors contribute to the differences in cost between MA and private insurers, including the severity of the disorder and private sector deductible and co-pay requirements, utilization controls, and limits on the types of services available. Another possible factor is the concern voiced by several of the county officials we talked to that private insurance companies are not being billed for services prior to Medical Assistance for those MA eligibles that may have other insurance.

Efforts to Control Public Mental Health Expenditures

The Commonwealth has undertaken several initiatives to control and/or reduce MA expenditures pertaining to children's mental health care services. The efforts highlighted in this report include those to recover MA expenditures from liable third parties, the expansion of managed behavioral health care to all counties, and a program that pays the premiums for employer-sponsored health care when the cost of such insurance is less than that of Medical Assistance.

Efforts to Determine Third Party Liability

Certain stakeholders indicated that, at least historically, the Department of Public Welfare has not been aggressive in determining third party liability. One of the challenges in the payment system for mental health services is to ensure that Medical Assistance is the payer of last resort as required by federal law. The Social Security Act, 42 U.S.C. §1396(a)(25), requires DPW to operate a program to recover the costs of MA expenditures from liable third parties.

During our review, several county officials expressed concerns that private insurance companies are not being billed for services before Medical Assistance. To address this concern and fulfill its federal obligation, DPW has exchanged data, as discussed below, with health insurance entities (including insurance companies, and pharmacy benefit companies) to identify those who are receiving services paid for by Medical Assistance who also have private insurance. DPW has operated this program for approximately 12 years using a contractor for the majority of the entities.[2] The Department conducts the data match for the Blue Cross and Blue Shield plans. The Department and its contractor negotiated with the companies for the data exchange since, until Act 2005-42, there was no requirement that this information be provided. Prior to this act, not all companies participated. According to a DPW official, in 1998 approximately 30 to 40 entities participated. During 2005, 136 entities participated.

The process works as follows: when MA pays a claim, the contractor and the Department seek a match between a policy in their data base and the name of the client for which MA paid the claim. If there is a match, the contractor or Department bills the company, which then pays DPW. The client and company are listed in the Eligibility Verification System so future services will be charged to the health insurance entity first before proceeding to MA. Since FY 2001-02, this matching has resulted in payments from the health insurance entities to the Department of approximately $72.8 million. Please see Table 9 on the next page for additional information. A DPW official has recommended that the Department seek insurance information from clients prior to services being provided since it would save both the initial payment as well as the costs paid to the contractor for fund recovery.

Act 2005-42, passed in July 2005, requires health insurance entities to provide information on health insurance coverage and benefits to DPW. This should provide a more thorough review of the available insurance for individuals who receive services paid for by MA since all insurers are now required by law to provide this information to the Department.

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[2] An RFP was issued last year when the contract was scheduled to expire. A new contract was awarded at the end of the year and the new contractor is transitioning with the former contractor. The Department is negotiating whether the contractor will be responsible for certain of the Blue Cross and Blue Shield companies. The contract is for two years with an optional renewal for three additional one-year periods.

Table 9

MA Amounts Recovered

Fiscal Year	Total Amount Recovered[a]	HMS Fee[b]
2001-02	$12,575,819	$ 848,865
2002-03	12,424,438	838,650
2003-04	22,811,713	1,562,863
2004-05	24,985,553	1,806,610

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[a] This represents the funds recovered in a given year. Those funds may have been expended in a different year as the department is authorized to "reach back" five years to recover funds. This includes all MA funds and is not limited to expenditures for mental health services for minors.

[b] Health Management Systems, Inc., was the contractor during this time frame.

Source: Developed by LB&FC staff using information obtained from the Third Party Liability Division in the Department of Public Welfare.

One related problem encountered during the payment process had been the use of local (DPW only) codes by providers submitting claims for services. As a result, MA was being billed for services that may have been covered by private insurance. This coding incongruity, however, has been overcome during the past two years with the installation of the PROMISe™ data system, and DPW now uses local codes only for its waiver programs, such as the PDA waiver and the Michael Dallas waivers. Providers know that these services are not covered by private carriers and, therefore, submit claims only to DPW. Officials within DPW believe that only 10 percent of the service codes are local/DPW only codes.

Expansion of Behavioral Health Managed Care System (HealthChoices)

In 1997, OMHSAS implemented a HealthChoices behavioral health managed care "carve-out" in Pennsylvania's five southeastern counties, meaning behavioral health was separated from the physical health HealthChoices Program. In 1999 and 2001 respectively, the 10 southwest counties and 10 counties in the Lehigh/ Capital area began managed care. Implementation of physical and behavioral health benefits occurred simultaneously. County government was offered "the right of first opportunity" to manage the HealthChoices behavioral health program.

Twenty-four of the 25 HealthChoices counties hold the contract for the behavioral health program, and DPW manages the contract for Greene County. With each expansion of HealthChoices, DPW has realized savings compared to the Fee-for-Service program. The initial and ongoing savings have resulted in about $190 million in "reinvestment" funds being invested back into local county mental health and drug and alcohol services. DPW also credits HealthChoices for decreasing the rate of spending growth in the MA program.

In July 2005, DPW announced plans to expand HealthChoices in four northeast counties: Lackawanna, Luzerne, Susquehanna, and Wyoming. Implementation is scheduled for July 2006, and the county commissioners in all four counties accepted the right of first opportunity to manage the program and have selected their BH-MCO vendor.

In January 2006, citing the goal of a unified behavioral health system in every county, OMHSAS proposed an expansion plan for the remaining 38 counties not in the HealthChoices program and sent a letter of intent to each asking if they would elect to accept the right of first opportunity. Twenty-two counties[3] are included under a DPW-held contract with one BH-MCO, which is scheduled for implementation in January 2007. The other 16 counties[4] elected the right to manage the program, and the implementation for these counties will be in July 2007.

The expansion is designed to be budget neutral with only incidental savings in the first few years, especially in the more rural counties. The Governor's FY 2006-07 budget anticipates a savings from this expansion of $3.14 million. DPW estimates that by year two of the plan, they will have realized $7.1 million in savings. Additional savings from economies of scale are expected in later years. Improved access to services, as well as controlling expenditure growth, are the immediate goals of the expansion, according to the OMHSAS Deputy Secretary.

OMHSAS needs approval from the Center for Medicare and Medicaid Services (CMS) to expand the current HealthChoices waiver authority statewide for behavioral health services. As of May 2006, DPW was preparing the request for CMS review and expected CMS approval to be forthcoming. According to DPW, the number of persons served has increased in each consecutive year of HealthChoices, and penetration rates in both mental health and drug and alcohol services have met or exceeded national benchmarks.

Declining Cost Per Recipient in Philadelphia. Philadelphia County, one of the first to implement MA managed care behavioral health, has found cost savings through HealthChoices. Three-year trend data for the Philadelphia HealthChoices system shows that the cost of MH services per unique recipient under the age of 18 has decreased each year since 2002. It appears that managed care is having an impact, because the overall number of unique clients increased each year, but the total amount paid out has decreased. See Table 10.

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[3] They are: Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne counties. Bradford/Sullivan, Cameron/Elk, Clearfield/Jefferson, Columbia/Montour/Snyder/Union, Forest/Warren, and Huntingdon/Mifflin/Juniata operate as county joinders for the delivery of county-administered mental health and drug and alcohol services.

[4] The counties include: Bedford, Blair, Cambria, Carbon, Clinton, Crawford, Erie, Franklin, Fulton, Lycoming, Mercer, Monroe, Northumberland, Pike, Somerset, and Venango. Bedford/Somerset, Franklin/Fulton, Lycoming/Clinton, and Carbon/Monroe/Pike operate as joinders.

Table 10

Impact of HealthChoices Behavioral Health
(Philadelphia – Community Behavioral Health)
(Under age 18)

	2002	2003	2004
Total Amount Paid	$218,723,530	$204,465,412	$197,286,688
Total Unique Service Recipients	36,087	36,449	38,734
Total Cost Per Recipient	$6,061	$5,610	$5,093

Source: Developed by LB&FC staff from information provided by Community Behavioral Health.

Commercial managed behavioral health care has come to dominate many private insurance programs and public sector mental health programs. A survey conducted of employers with 10 or more employees found that 22 percent of eligible employees were enrolled in indemnity plans and 78 percent were covered by managed care. Utilization reviews, benefit designs, and payment policies under managed care have influenced where and how treatments are provided, with outpatient care emphasized over inpatient care and pharmacotherapy over psychotherapy.

Declining Costs Per Member Per Month for Community Behavioral Health Network of Pennsylvania (CBHNP).[5] The trend data from CBHNP between October 2003 and October 2005 (see Exhibit 6) shows that the overall cost per member per month (calculated using all members, not just children receiving services) has declined while the overall number of units of service has remained about the same. Individual service categories contributing to the overall trend include BHRS (discussed in Chapter IV.B) and RTF, Outpatient, and Community and Ancillary Services (see Appendix K). The increases in Outpatient Services and Community and Ancillary Services and decreases in RTF services would appear to mirror the national trend of emphasizing outpatient and community services over inpatient and residential treatment.

Declining Costs Per Recipient in Allegheny County (Community Care Behavioral Health Organization-CCBHO). CCBHO, through the Allegheny County Department of Human Services, provided us with certain trend data on costs per 18 and under member who received services. Community/ancillary cost per recipient trended upward from January 2004 through December 2005, while outpatient cost per recipient remained about the same. However, for several other key and high-cost services, such as BHRS and RTF, cost per service recipient trended downward for the period. (See Exhibit 7.)

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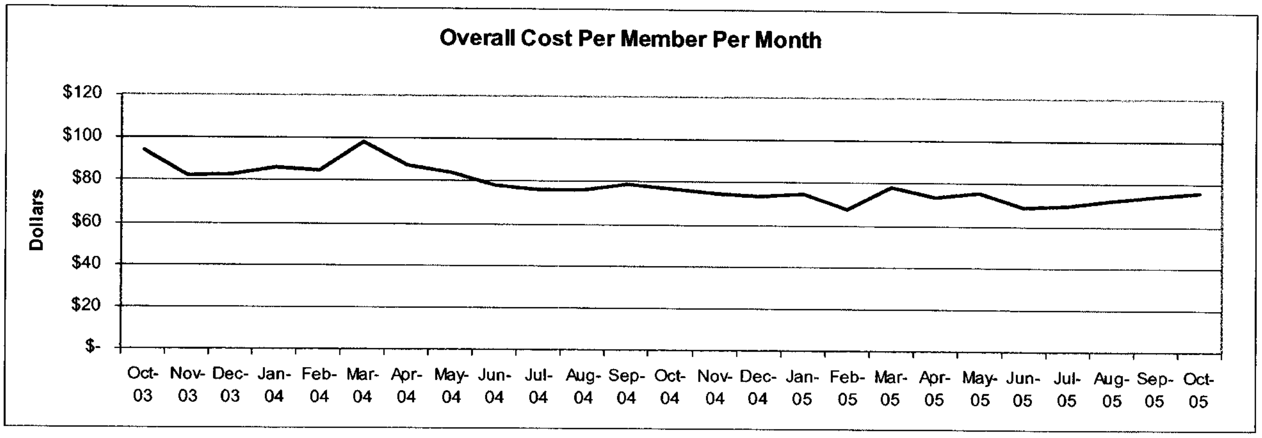
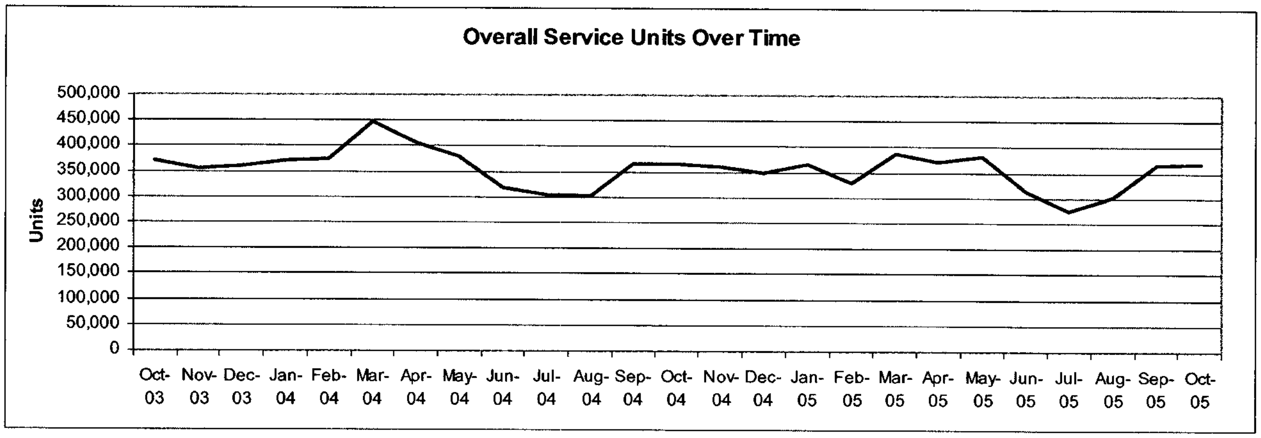
[5] CBHNP is the HealthChoices behavioral health managed care contractor for southcentral Pennsylvania, including Cumberland, Dauphin, Lancaster, Lebanon, and Perry counties.

Exhibit 6

CBHNP Cost and Service Data



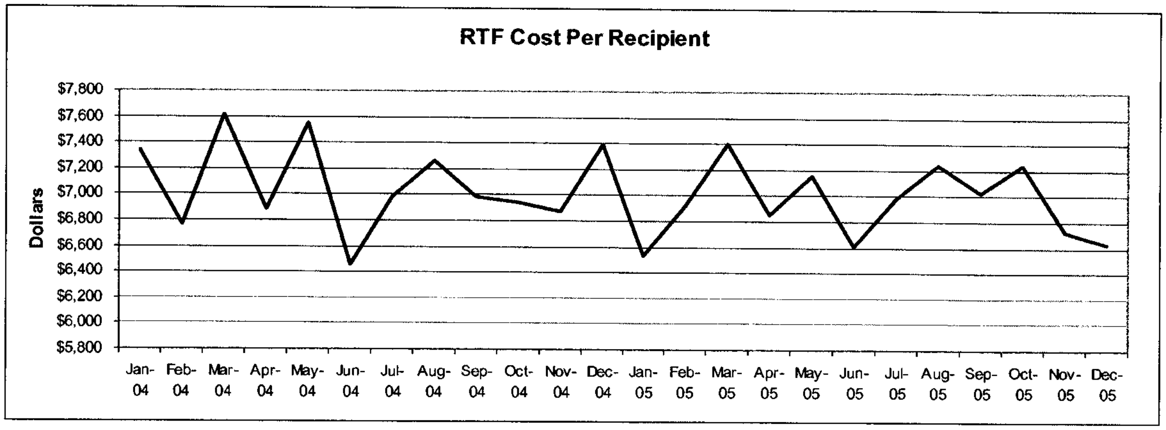


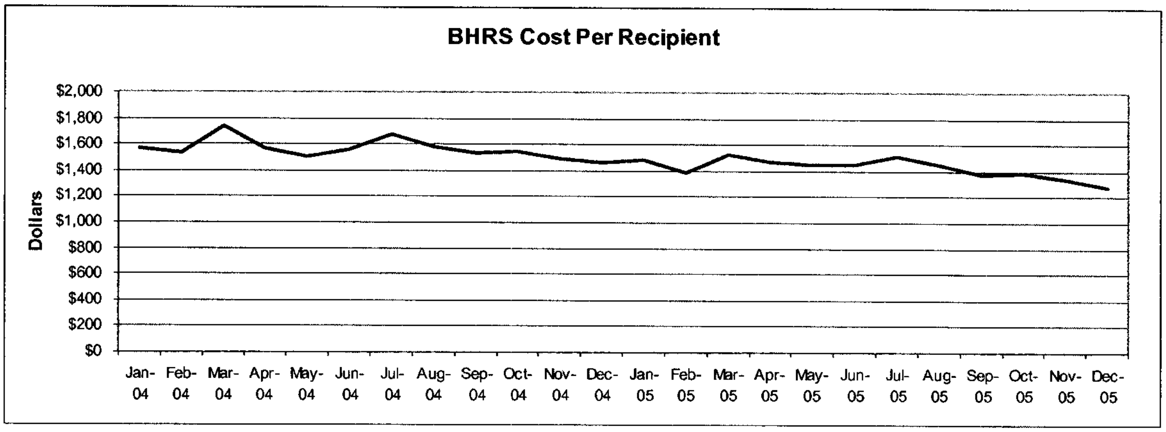
Source: Developed by LB&FC staff from information provided by CBHNP.

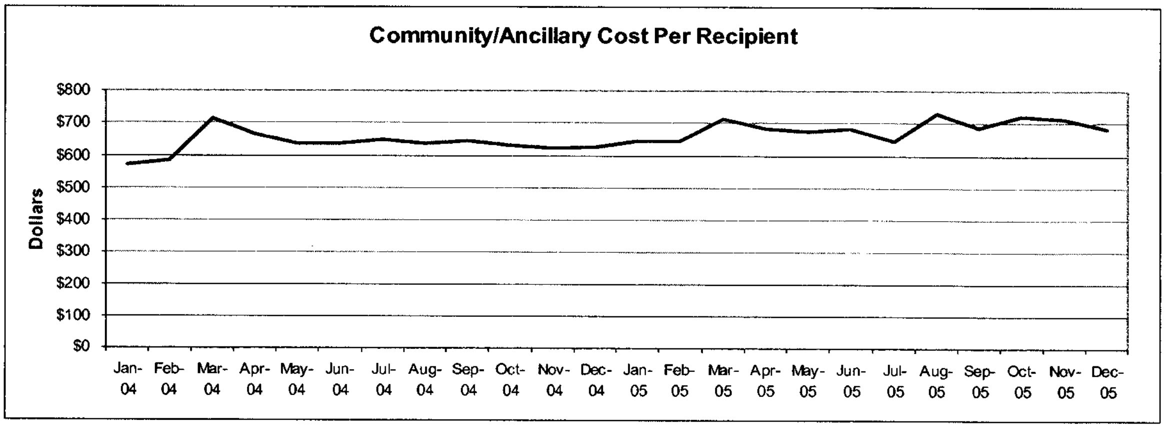
Administrative Costs of Managed Care. The cost containment possible through managed care may be offset to a degree by additional layers of administrative oversight. In the opinion of one provider group, the introduction of managed care has resulted in new layers of administrative oversight at the state and county level as well as the administrative oversight functions of the MCO and provider administrative systems for billing and support. The group expressed concern that, although managed care has controlled costs in some ways and improved access to services, it has also reduced dollars available for services. The stakeholders noted that DPW does not report how such administrative costs impact dollars available for services.

Exhibit 7

CCBHO Cost Per Recipient for Selected Service Categories







Source: Developed by LB&FC from information provided by CCBHO.

HIPP – Health Insurance Premium Payment Program

The Omnibus Budget Reconciliation Act of 1990 (OBRA) required all states to enact a program to identify cases in which enrollment of a Medicaid recipient in a private group health plan is more cost effective than a Medicaid plan. Enrollment in a group health plan is considered cost effective if anticipated Medicaid payments are greater than the premiums and cost sharing obligations under an employer group health plan for those services. DPW's Bureau of Financial Operations has responsibility for Pennsylvania's Health Insurance Premium Payment (HIPP) Program.

The purpose of HIPP is to save taxpayer dollars by purchasing employment-related medical insurance that is available to Medical Assistance clients. Active MA recipients who have access to medical insurance through employment are referred to HIPP, and DPW conducts a cost analysis based on who is eligible for the employer insurance, the amount of the premium, and the policy benefits. Those cases determined to be cost effective are negotiated with employers, insurance carriers, and/or recipients to enroll the recipients in the employer group health insurance. If the available employer health insurance is determined to be cost effective, the client is required to participate in the HIPP Program as a condition of continued eligibility for MA. If the recipient is in managed care (HealthChoices), they are automatically disenrolled, and the employer insurance becomes the primary payer.

DPW officials report that as of May 2006 there were 23,763 individuals (adults and children) enrolled in the HIPP program. The Department paid $32,281,659 in premiums and calculates that $87,814,787, or about $3,695 per enrollee, has been generated in savings to date for FY 2005-06.

IV.B. The Cost, Availability, and Timeliness of Wraparound Services Have Been Problematic

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services were created in the 1960s and expanded by the federal Omnibus Budget Reconciliation Act (OBRA) of 1989 to provide "necessary health care, diagnostic services, treatment, and other measures described in [the statute] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." Due to these provisions, "wraparound services" became available in Pennsylvania in the early 1990s and are paid for through the Commonwealth's Medicaid program.

Wraparound services in Pennsylvania include Mobile Therapy, Behavioral Specialist Services, and Therapeutic Staff Support. These services are defined as:

- Mobile Therapy: A mobile therapist provides intensive therapeutic services to a child and family in settings other than a provider agency or office. Services can include: assessment, determination of any necessary family support services, provision of psychotherapy, and collaboration with the child, family, and other professionals to provide unified services and continuity of care to the child and family.
- Behavioral Specialist: A behavioral specialist, with other members of the treatment team, designs and directs the implementation of a behavioral modification intervention plan; identifies behavioral goals and intervention techniques; and recommends behavioral change methods. The specialist, while maintaining some direct contact with the child and family, primarily provides assessment, program design, and monitoring rather than direct therapy.
- Therapeutic Staff Support: A TSS worker provides one-on-one interventions to a child at home, school, or some other community setting. Specific services include: crisis intervention techniques, immediate behavior reinforcement, emotional support, time-structuring activities, time-out strategies, and additional psychosocial rehabilitative activities as prescribed in the treatment plan.

Wraparound services may be delivered in the child's home or school at no cost to the child or family receiving the services, regardless of family income. Pennsylvania's approach to these wraparound services appears to be somewhat unique in that reportedly most states do not include especially TSS services to the extent that Pennsylvania does.

The cost of BHRS services by the HealthChoices and the Fee-for-Service systems for children was $437 million in CY 2003. This represents 60 percent of all mental health MA expenditures for children for that year. Of this total, almost $259 million, or about 60 percent, were for TSS services.

Timeliness of Wraparound Services

The length of time it takes to receive wraparound services was the focus of a lawsuit brought against DPW in 1999. Kirk T. is a class action lawsuit brought on behalf of a class of MA recipients under the age of 21 who are or will be authorized to receive behavioral health services. The complaint alleges that children were waiting for months to receive behavioral health rehabilitation services, specifically mobile therapy, behavioral specialist consultant, and therapeutic staff support, known together as wraparound services. The court found that DPW was violating federal Medicaid law by failing to provide these services with reasonable promptness.[1] This finding was limited to TSS. The count did not address mobile therapy or behavior specialist consultant services. The court held that DPW violated the reasonable promptness section because it had not established a standard to measure that services were initiated in a timely fashion, and it was, therefore, unable to determine whether services were timely, as defined by the Department.

After the ruling, DPW entered into a settlement agreement with the plaintiffs which required:

- DPW to adopt a 60-day standard for the delivery of these services;[2]
- reductions in frequency of interagency team meetings for minors who receive services from no more than two service delivery systems;
- changes to TSS qualifications, training, and supervision; and
- data collection and reporting to measure whether authorized services are delivered within the prescribed time frame.

In January 2004, the agreement was amended to revise the reporting requirements but retained the other provisions of the agreement.[3] The parties agreed to extend the agreement due to the formation of the Task Force on Children's Behavioral Health convened by the new Secretary of Public Welfare, but wanted assurances that no major disruption or changes occur in the BHRS delivery system. The revised reporting standards require the providers to report the number of service hours of TSS authorized and the number of service hours of TSS for which claims were paid. The purpose was to provide trend information to ensure that the system did not worsen during this period.

While not addressing timeliness of service directly, the provider data suggests that no significant change in service delivery has occurred. Data from the reports submitted by the providers since January 2003 show that the system's service

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[1] The Social Security Act, 42 U.S.C. §1396a(a)(8), requires Medicaid services to be provided "with reasonable promptness to all eligible individuals."

[2] Compliance with the 60-day timeliness standard is measured as 50 days from the date of the evaluation to the date services were first delivered as authorized.

[3] The original settlement agreement required detailed data collection by the providers on the BHR services. Reportedly, due to its difficulty, the data collection was not done well and was not considered particularly useful to the parties in determining timeliness.

delivery has remained at roughly the same level, about 60 percent of TSS hours authorized, through April 2005. (See Table 11.) The hours paid by the Fee-for-Service system is a slightly greater percent of the hours authorized than is the percent of hours paid to hours authorized by the HealthChoices system.

Table 11

TSS Hours Paid as a Percent of TSS Hours Authorized

	HealthChoices	Fee-For-Service
2003.................	61.4%	N/A
2004.................	59.0	67.2%
2005[a]................	60.2	67.8

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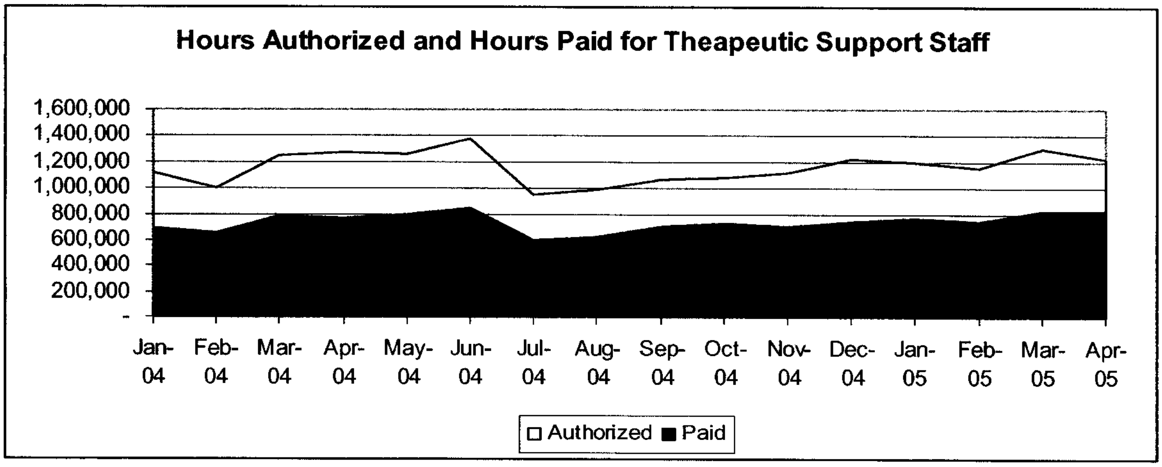
[a] January through April only.

Source: Developed by LB&FC staff using information provided by the Department of Public Welfare, Office of General Counsel.

In addition, Exhibit 8 below shows the combined HealthChoices and Fee-for-Service hours authorized and paid for CY 2004 and CY 2005 through April. As can be seen, the difference between hours authorized and hours paid for TSS services has remained fairly constant.

Exhibit 8



Source: Developed by LB&FC staff using information provided by the Department of Public Welfare, Office of General Counsel.

As a result of the continuing issues with timeliness of service delivery and because the work of the task forces was taking longer than anticipated when the amended agreement was initially signed, the Disabilities Law Project filed a motion to reinstate the case in fall 2005, although negotiations with the Department were ongoing as of May 2006. The preliminary results of the Behavioral Health Task Force were expected to be available by May 2006. (See also Chapter III.A.)

Concerns With TSS Services

Therapeutic Support Services (TSS) are one part of the behavioral health rehabilitative services (BHRS) program, also known as wraparound services. These services are delivered in the home or in school in the context of the child's daily life. TSS is intended to provide active, individualized treatment to the child. Throughout our review of children's behavioral health services, we were advised of several issues with this particular program.

Overprescription of TSS

Since TSS is a covered service under Medical Assistance in Pennsylvania, if the service is deemed medically necessary for a child, the child will receive the service. In our surveys of county MH/MR directors, several cited that BHRS services are overused, including that they are overly relied upon to the exclusion of other services and that the services are used for too long a period of time. According to one provider group, service prescriptions need to be developed with goals that have specific time frames and, if progress has not been made within these time frames, a different prescription should be developed. The group cites several reasons why BHRS services, specifically TSS services, have proliferated significantly:

- in the early 1990s, with the lack of MH services, the state encouraged the use of BHRS to expand services in a way that would allow for MA dollars to pay for this service;
- at the same time, counties shifted county funded services to the BHRS funding stream;
- other systems serving children, such as the welfare system, were able to refer youth to BHRS services, regardless of the family's income or insurance;
- families and advocates demanded increasingly more TSS services; and
- state and county governments encouraged new providers to offer BHRS services.

Training of TSS workers

One of the results of the Kirk T. settlement was a change in who may qualify to be a TSS worker. The purpose in making the requirements less restrictive was to expand the pool of potential applicants available to fill positions by expanding the type of training and experience needed to qualify as a TSS worker. As a result, requirements for a TSS worker are as follows:

- bachelor's degree in psychology, social work, education, criminal justice or a related human service field;

- bachelor's degree in any other field with one year of experience in paid work that involved direct contact with children and adolescents;
- associate's degree, or 60 credits toward a degree, with three years experience in paid work that involved direct contact with children and adolescents;
- licensed registered nurses with one year of paid work that involved direct contact with children and adolescents; and
- licensed practical nurses with three years experience in paid work that involved direct contact with children and adolescents.

Parent groups and certain other stakeholders with whom we spoke expressed concern that these requirements are not stringent enough, in part because any type of bachelor's degree is acceptable. These parents are concerned that even with a degree in human services, many TSS workers are coming straight from college, are not parents, and are not interested in children.

Training standards for new TSS workers require 15 hours of training before working without a supervisor present. An additional 24 hours are required within the first six months on the job and 20 hours each year thereafter. In addition, the Department has issued a Bulletin stating that oversight, assessment, and assistance be rendered to TSS workers with either less than or equivalent to six months of full-time experience or those newly hired by a provider with the equivalent of six months or more full-time experience. TSS services are billable under MA and can include a supervisor accompanying the TSS worker to an appointment with the child and observing interactions between the TSS worker and the child/family, functioning as the lead role model regarding appropriate interactions between the child/family during appointments, or monitoring the TSS worker's skills and abilities.[4]

TSS Policies Only Allow Contact if a Behavioral Problem Occurs

Another issue is that a TSS worker may not come to the aid of a child unless a behavioral problem occurs. For example, if a child is having difficulty with multiplication problems in the classroom and is becoming frustrated, the TSS worker may not help with school work, but may only help the student when he/she begins to act out. The direction for TSS workers for what is inappropriate billing and delivery of TSS services came from a letter from the Department in January 1998. The letter includes a listing of such inappropriate activities and states that the list is not limited. Examples of such activity include:

- providing services not included in the child's treatment plan;
- performing the duties of school personnel such as teacher or teacher's aide;

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[4] The supervisor who observes the interactions between the TSS worker and child does not bill for TSS services but bills for "assessment and assistance," which has a much lower rate than TSS services and can be provided only for six hours for a TSS worker with less than six months of experience and three hours for a TSS worker with six or more months of experience.

- academic tutoring;
- therapy or counseling rather than supportive and clarifying interactions with child and family, consistent with the child's treatment plan;
- respite care; and
- developing relationships with the purpose of providing a role model (i.e., Big Brother/Sister) or time spent with the child providing no mental health interventions.

As a result, according to various stakeholders we spoke to during this study, TSS workers sometimes may sit in the back of classrooms doing recreational activities, such as reading or doing crossword puzzles, while watching the child to whom they are assigned.

TSS Uses 60 Percent of the BHRS Budget, but There Are No Outcome Reviews to Support Its Effectiveness

In 2003, BHRS expenditures were over $437 million; 60 percent of this total, almost $260 million, was spent on TSS. Despite this level of expenditures, little has been done to determine if TSS is an effective mental health service. Some BHMCOs have implemented programs to measure TSS outcomes; these programs use various assessment tools to determine if BHRS is an intervention that is helping children with mental illness make progress. (See Section III.B).

TSS Historically Has Not Measured Outcomes. At the November 2005 meeting of the Governor's Advisory Commission on Families and Children, Dr. Mark Greenburg, Director of the Prevention Research Center at Penn State University, spoke about using evidence-based practices in addressing mental health disorders in children. He also pointed out the importance of systems integration across levels of care, developmental stages, and institutional structures (see also Chapter III.B.) Further discussion with Dr. Greenburg reinforced that there has been little assessment of TSS to determine if it is having a positive effect on children's mental health. In his opinion, a small pilot study would represent a significant effort to understanding the impact of TSS, a service which is available in a relatively few states.

According to Dr. Greenburg, such a study would not only serve to determine TSS' impact, but would serve to aid understanding for which diagnoses TSS can be most effective and how many hours per week are most effective for each diagnosis. The study should account for age and severity of diagnosis, as well as other variables that can affect treatment. By creating a group that receives a modified model of TSS services, the effectiveness of TSS could be measured. Such a study could potentially be used on a broader scale and/or related data be required to be collected statewide.

DPW Deputy Secretary of OMHSAS indicated that such an evaluation, while beneficial, could potentially affect progress with stakeholders' groups over level of service issues, especially as regards plaintiffs in the Kirk T. case referenced above. Exhibit 9 briefly delineates what such a study might contain. Dr. Greenburg estimates the cost of this type of study would be minimal, $150,000 to $200,000, in comparison to TSS expenditures (approximately $300 million in FY 2004-05). A statewide outcomes review of TSS would, of course, cost significantly more.

Exhibit 9

Key Factors Pertinent to a Pilot Study of TSS

- Diagnosis of the child
- Severity of diagnosis
- Number of TSS hours based on diagnosis
- Age of the child
- Services child is receiving, i.e., TSS alone or in combination with other services
- Regional differences, i.e., rural or urban; or location in Pennsylvania
- Location of TSS services, i.e., school or home environment
- TSS provider qualifications and training
- Rates paid to TSS workers
- Activities performed by TSS workers
- Coordination between TSS workers and others (e.g., teachers)

Source: Developed by LB&FC staff in consultation with Dr. Mark Greenburg at Penn State University.

A second study that would compare standard TSS services to other TSS models, such as those in use in Philadelphia, could also be helpful to assess the effectiveness of varying approaches to TSS service delivery in terms of outcomes and efficiency and would help to determine the best manner of delivering this service.

Actions to Improve the Efficiency and Effectiveness of BHRS Services and Reduce TSS Costs. According to many of the groups and officials we spoke with, multiple TSS workers (one per child) is not an efficient or productive use of resources in a classroom setting. We were told of instances in which as many as eight TSS workers were sitting on chairs in the back of a school classroom. Group TSS has been offered as part of a solution and, in the case of Philadelphia, has also reduced TSS costs. However, there are several reasons why group TSS is difficult to achieve. These reasons include:

- treatment plans are designed around the individual child;
- the system focuses on consumer choice and consumers like TSS;
- free-market mentality allows agencies to market to the consumers; and
- parents demand an individual worker for their child.

In part as a way to moderate the number of hours of TSS services that are being prescribed and used, one behavioral health managed care organization has been developing alternatives to individualized TSS. These services include after school programs, therapeutic activity groups, summer therapeutic camps, and intensive day care. These programs are also considered BHRS services and are billed as such, in both Fee-for-Service and HealthChoices counties; but the MCO considers them to be of greater therapeutic value than individualized TSS.

As can be seen on Table 12 below, efforts by two behavioral health MCOs (CBH and CCBHO) to reduce the percent of BHRS dollars expended for TSS appears to have had an impact.

Table 12

TSS Percent of BHRS Expenditures

	CY 2003	CY 2004
CBH	65%	54%
	FY 2003-04	FY 2004-05
CCBH	56%	51%

Source: Developed by LB&FC staff using information provided by Community Behavioral Health and Community Care Behavioral Health.

Philadelphia Initiatives. The size of the TSS program in Philadelphia has declined as the SBBH and CARE programs have grown over the past three years.[5] As can be seen in the charts below, from 2003 to the end of 2005, the number of TSS clients decreased 36 percent, from 2,865 to 1,835. The number of SBBH and CARE clients, on the other hand, grew from 181 in the first quarter of 2003 to 879 in the last quarter of 2005. The ratio of TSS clients to SBBH and CARE clients went from 16:1 in 2003 to 2:1 in 2005. Combined, the number of unique clients went down almost 15 percent, from 3,007 to 2,563 (see Exhibit 10.).

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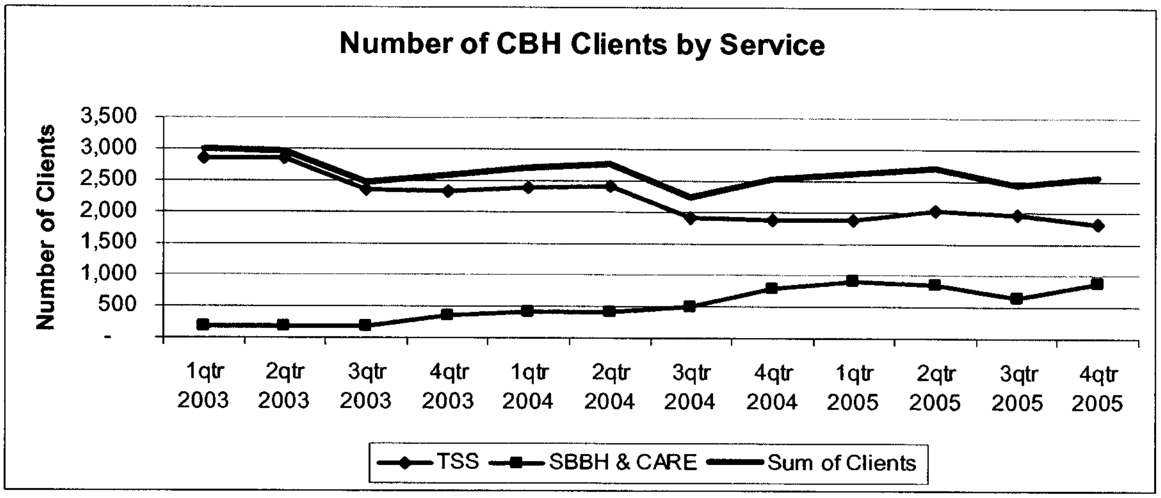
[5] School-Based Behavioral Health (SBBH) provides mental health services for students with intensive needs. This program is designed to replace individual TSS workers with a behavioral health team at each site. The teams provide support, therapy, and interventions in the classroom. The Children Achieving through Re-Education (CARE) program is a self-contained, full-day behavioral health service using education for the provision of services. All students in the CARE program have been diagnosed as seriously mentally ill or emotionally disturbed. Students receive intensive, school-based behavioral health rehabilitative services in a public school setting.

Exhibit 10

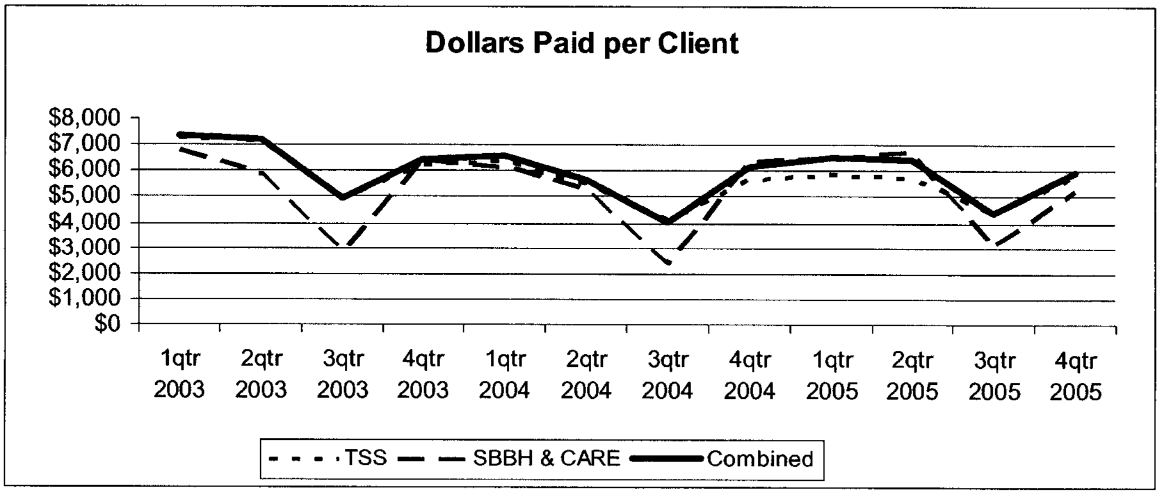


Source: Developed by LB&FC staff using information provided by Community Behavioral Health, Philadelphia.

Dollars paid per client for TSS were $7,306 for the first quarter of 2003 and $5,831 by the last quarter of 2005–a 20 percent drop. Dollars paid per client for SBBH and CARE were also down by about 24 percent, from $6,823 to $5,214, and overall dollars paid per client for combined TSS and SBBH and CARE were down 19 percent over the three-year period (see Exhibit 11.

The SBBH program in Philadelphia has reported outcome data for 2003-04. Seventy-one percent of the children in the program were reported to have made clinically significant, reliable change. Of the children making reliable change, 57 percent were considered partially recovered.

Exhibit 11



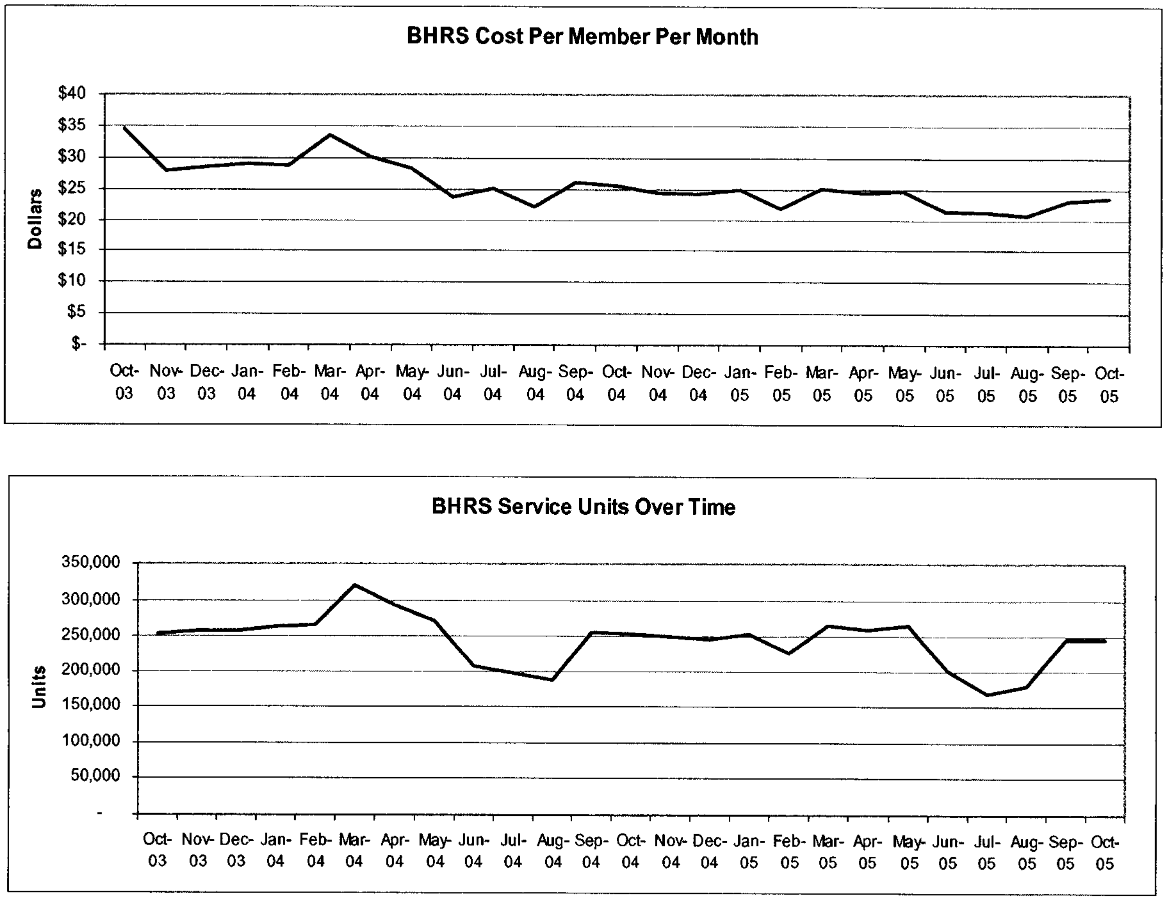
Source: Developed by LB&FC staff using information provided by Community Behavioral Health, Philadelphia.

Community Behavioral Health Network of Pennsylvania (CBHNP) Activities. Looking at BHRS for CBHNP, but using different measures, we see similar developments as those in Philadelphia. As can be seen in Exhibit 12, the cost per member per month (calculated using all members, not just children receiving services) has declined significantly while the units of service have declined only slightly.

Stepping Stones. Stepping Stones is an alternative, community-based program designed to improve the efficiency of therapeutic support services. The program, developed by Northwestern Human Services, has 18 facilities throughout Pennsylvania and is planning three additional sites in southeastern Pennsylvania. The program operates as part of the BHRS wraparound services for children with autism. There are two levels: one for children aged 2 to 6, the other for children aged 7 to 14. The program has 12 slots per site per session and runs from 4:00 p.m. to 7:00 p.m. after school, with the option for a three-hour Saturday morning session. Program effectiveness is measured through TSS worker evaluations and activities

Exhibit 12

CBHNP BHRS Cost and Service Units



Source: Developed by LB&FC staff from information provided by CBHNP.

and the progress a child makes. The target population is autistic students, and the program is based on one TSS worker per two clients as compared to the traditional 1-on-1 model.

Stepping Stones is approved as an alternative up to 15 hours per week, typically in conjunction with 15 hours of 1-on-1 TSS support services in the home or school. The program emphasizes higher level programming and activities with increased exposure to eight sensitivity topics, such as bullying, relationship building, and repairing subtle social skill errors. It provides an opportunity to build and practice self-esteem according to the program's description. Any child with an autism spectrum may be considered eligible for Stepping Stones.

NHS collects outcomes data in various categories of the Stepping Stones program, including clinical progress, individual goal attainment, parent satisfaction, and utilization information. Data is collected by location of service every six months. For example, from January to June 2005, children's scores on NHS's screening instrument improved in four of nine areas.[6]

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[6] The nine areas on the screening instrument include communication, play, safety, aggression, compliance, attention, environmental engagement, emotions/awareness, and social awareness.

IV.C. DPW's Integrated Children's Services Initiative (Medicaid Realignment) Has Created Concerns Among Counties and Stakeholders

The Integrated Children's Services Initiative (ICSI), also referred to as Medical Assistance Realignment, is an effort by DPW, the counties, and behavioral health providers to improve the delivery of behavioral health services through a coordinated planning process between behavioral health, child welfare, and juvenile justice systems. Specifically, ICSI is intended, at least in part, to implement the financing changes necessary to support the integration of behavioral health services for dependent or delinquent children into the Medical Assistance program. DPW began this initiative with a vision that children should have access to a comprehensive range of high quality services through the public system, regardless of how the child enters the system.

ICSI involves taking a look at all behavioral health services in the various child systems and identifying those services that would be appropriate to submit to Medicaid for payment. Medical Assistance funds are available to pay for services that meet the following criteria:

- The service is covered by the Medical Assistance Program.
- The service provider is enrolled in the Medical Assistance Program.
- The individual receiving the service is a Medical Assistance recipient.
- The services are medically necessary, as defined in the Department's regulations and contracts with the behavioral health managed care organizations (BH-MCOs).

DPW determined that only those services that have a treatment component that qualifies for MA reimbursement would be included in this transition. To identify qualified treatment components, the Department considered all behavioral interventions that include a clinical service component delivered in the home, school, or community, such as psychological and psychiatric evaluations; individual, group, and family therapy; day treatment programs; drug and alcohol services; community-based placement; and residential treatment.

Not all services currently reimbursed through the child welfare and juvenile justice systems are being transitioned to the Medical Assistance program. Those services that do not have a qualified treatment component, are delivered by a provider not enrolled in the Medical Assistance program, are provided to an individual who is not eligible for MA, or are determined to be not medically necessary will continue to be reimbursed consistent with the child welfare funding program. Child welfare funds continue to be used to support the provision of child welfare and juvenile justice services, including those that are court-ordered. In fact, only 4 percent of the FY 2005-06 child welfare/juvenile justice system budget (approximately $77 million) was targeted to be transitioned to MA funding; therefore, the same funding mechanisms remain available to county children and youth and juvenile justice agencies to pay for necessary services within their systems.

Budgetary Impacts of MA Realignment

For FY 2005-06 through FY 2006-07, DPW has budgeted $103.7 million in expenditures to extract from the child welfare needs-based budget and funded through the MA behavioral health system. A base reduction of $75.1 million in child welfare expenditures was taken from the total for all counties, with $68.9 million of this total coming from the HealthChoices counties. An additional $28.6 million in child welfare expenditures could be transitioned to Medical Assistance based upon county utilization.

If the $28.6 million is ultimately shifted from the child welfare to the MA budget, a special allocated amount specific to each county will be released to fund the state share of the county child welfare expenditures. To accomplish this, the Department has proposed establishing a special Behavioral Health Transition appropriation of $14.9 million to supplement the needs-based budget. See Table 13.

Implementation of ICSI/Medical Assistance Realignment

In FY 2004-05, the Department began to identify behavioral health treatment services, both residential and community-based, to determine whether and how these services could be paid by the Medical Assistance program. Realignment of residential facilities (each had to be a Chapter 3800 licensed facility) began with a five-county pilot program. Providers were identified, HealthChoices contracts were amended, and the payment methodology approved by CMS. On January 1, 2005, the Department began shifting the payment for certain behavioral health treatment services for eligible children and families to the Medical Assistance program in Allegheny, Philadelphia, Bucks, Luzerne, and York counties. With the exception of Luzerne, all counties in the pilot were HealthChoices counties.

The remaining counties were brought into the process, and a statewide transition began July 1, 2005. At that time, 23 providers and 50 new programs were enrolled in the Medical Assistance Program. By March 2006, enrollment has grown to 42 accredited providers, 20 new Home and Community programs, and 80 non-Joint Commission on Accreditation of Healthcare Operations (JCAHO) accredited facilities. DPW reports that, as of April 2006, the majority of the residential programs willing to participate have now been enrolled, and their focus has shifted to non-residential programs. For example, Multisystemic Therapy programs are being considered as an alternative to residential placement.

Table 13

County Child Welfare NBB – MA Realignment

(FY 2004-05 Through FY 2006-07)

County	Child Welfare Expenditures Identified for MA Realignment	Additional Child Welfare Extraction Associated With Special Appropriation	Total Expenditures Identified for MA Realignment	Special Appropriation (State Share of Additional CW Extraction)
Adams	$ 71,853	$ 180,573	$ 252,426	$ 89,699
Allegheny	15,820,347	5,521,634	21,341,981	2,859,271
Armstrong	172,508	407,515	580,023	250,478
Beaver	492,316	292,626	784,942	147,272
Bedford	47,056	0	47,056	0
Berks	173,387	1,395,593	1,568,980	711,566
Blair	272,052	0	272,052	0
Bradford	0	0	0	0
Bucks	1,797,815	1,285,924	3,083,739	665,495
Butler	383,219	627,454	1,010,673	348,176
Cambria	157,000	0	157,000	0
Cameron	37,934	0	37,934	0
Carbon	0	0	0	0
Centre	42,250	0	42,250	0
Chester	1,573,872	1,145,223	2,719,095	636,354
Clarion	9,744	0	9,744	0
Clearfield	113,792	0	113,792	0
Clinton	60,000	0	60,000	0
Columbia	26,623	0	26,623	0
Crawford	443,992	0	443,992	0
Cumberland	100,000	301,989	401,989	203,597
Dauphin	1,121,706	2,261,219	3,382,925	997,225
Delaware	644,900	299,594	944,494	146,861
Elk	0	0	0	0
Erie	2,366,253	0	2,366,253	0
Fayette	616,141	0	616,141	0
Forest	7,628	0	7,628	0
Franklin	110,187	0	110,187	0
Fulton	0	0	0	0
Greene	323,550	0	323,550	0
Huntingdon	2,469	0	2,469	0
Indiana	151,583	462,902	614,485	284,594
Jefferson	26,120	0	26,120	0
Juniata	8,750	0	8,750	0
Lackawanna	169,023	0	169,023	0
Lancaster	892,875	1,520,554	2,413,429	795,931
Lawrence	280,121	1,138,335	1,418,456	592,318
Lebanon	80,474	539,958	620,432	256,814
Lehigh	376,977	3,539,190	3,916,167	2,050,094

Table 13 (Continued)

County	Child Welfare Expenditures Identified for MA Realignment	Additional Child Welfare Extraction Associated With Special Appropriation	Total Expenditures Identified for MA Realignment	Special Appropriation (State Share of Additional CW Extraction)
Luzerne	$ 524,405	$ 0	$ 524,405	$ 0
Lycoming	64,764	0	64,764	0
McKean	34,032	0	34,032	0
Mercer	184,503	0	184,503	0
Mifflin	29,531	0	29,531	0
Monroe	267,201	0	267,201	0
Montgomery	1,288,389	1,123,637	2,412,026	588,299
Montour	5,214	0	5,214	0
Northampton	141,304	949,222	1,090,526	347,391
Northumberland	38,250	0	38,250	0
Perry	67,256	253,996	321,252	131,835
Philadelphia	39,341,217	0	39,341,217	0
Pike	54,557	0	54,557	0
Potter	16,245	0	16,245	0
Schuylkill	141,304	0	141,304	0
Snyder	76,776	0	76,776	0
Somerset	19,122	0	19,122	0
Sullivan	0	0	0	0
Susquehanna	0	0	0	0
Tioga	6,194	0	6,194	0
Union	22,383	0	22,383	0
Venango	526,020	0	526,020	0
Warren	111,174	0	111,174	0
Washington	995,671	1,179,924	2,175,595	632,383
Wayne	0	0	0	0
Westmoreland	1,615,152	3,333,256	4,948,408	1,707,139
Wyoming	0	0	0	0
York	582,934	851,494	1,434,428	416,674
Total	$75,128,115	$28,611,812	$103,739,927	$14,859,466

Source: DPW Needs-Based Budget transmittal.

Implementation Concerns and Issues

In none of the meetings we conducted with county human services personnel, behavioral health service providers, or other stakeholders was there any objection to the stated goal of seamless entry and service delivery across all systems. However, the manner and speed with which the initiative was implemented has remained of concern to a noteworthy number of counties and stakeholders.

According to stakeholders, they are concerned that they were not fully included in the development of the initiative nor were they an integral part of the implementation planning. Provider groups felt that there was little guidance for MA realignment and no one accountable person to turn to for clarification. DPW did not issue written guidelines until July 2005, almost a year after preliminary work began on realignment, although the project began with four pilot counties in January 2005. Some of the county officials we talked to indicated that initially there were mixed messages from DPW, and this led to a degree of ambiguity and inconsistency.

Examples of concerns and issues brought to our attention included:

- Several questionnaire responses as well as field interviews noted that the pace of implementation was too quick, and there was concern that the impacts of realignment had not all been considered.
- The providers we talked to agreed that integration was a good goal and that it needs to happen, but they also commented that the execution of the program has been a problem. They receive written notification of changes, but are not sure that services are truly being integrated and would like to see indicators that the systems will be linked at certain points.
- One county we visited underwent a similar realignment process on their own a few years ago, and officials claim there is little more they can do now to meet the targets set by DPW.
- DPW is seen as taking existing beds and switching who pays to put children in those beds, while adding little additional assessment services. No new beds are being made available.
- Providers delivering services in more than one county reportedly present an implementation difficulty if each of the affected counties cannot agree that this provider's programs are to be transitioned to MA funding.
- Another concern expressed by the provider community was that Medical Assistance billing and paperwork requirements, staffing numbers and expertise requirements all increase costs for residential treatment facilities (RTF). It then becomes difficult to cover these costs with the resulting lower rates paid by MA.
- More than one county speculated that the state may not have sufficient funds to cover its share of the increased MA costs if the counties exceed the overall goal.
- Some county officials told us that if they were to flip all of the services that needed to be flipped to MA, there was a possibility that the county would not

have the Act 148 dollars available in the county budget to pay for other needed services.

- Officials in one county we visited expressed concerns because they could not get an explanation from DPW as to how the county realignment targets were calculated. They pointed out that DPW had taken away funding without a replacement. As a result, some services could not be provided or may not be provided in as timely a manner as previously. Counties also reported concerns that they may be forced to cut mandatory services to meet realignment targets.
- One issue raised was whether both MA and child welfare funds can be used to pay for services at an RTF that has enrolled in the MA program.

Juvenile Justice Concerns

According to officials with the Juvenile Court Judges' Commission (JCJC), there are significant numbers of youth with mental health problems in the juvenile justice system. Currently, state and local child welfare funds, as well as federal and state Medical Assistance funds, pay for MH services for these children. JCJC officials expressed concerns that relying more on federal Medical Assistance monies to pay for treatment provided in conjunction with a juvenile justice delinquency case disposition may result in state dollars not being available to pay for necessary services that cannot be funded by MA.

Another JCJC concern is that the switch to MA funding will require additional assessments, clinical evaluations, and approvals for payment that may cause delays in accessing the needed therapies. In particular, under MA there has to be a determination of medical necessity, which will have to be done by a psychiatrist or a psychologist. JCJC officials were reluctant to estimate the percentage of youth who may qualify for MA reimbursable services under this standard, stating that a full year of paid claim experience is necessary to estimate its real impact. The JCJC official also stated that concerns have been expressed regarding how being "labeled" with a medically defined mental health diagnosis as a juvenile could impact that juvenile later in life.

Juvenile justice programs are being identified as mental health programs so that they can qualify for MA reimbursement (the Community Intensive Supervision Program, for example). This change is being imposed upon the youth already in the system, and some, including the Pennsylvania Council of Chief Juvenile Probation Officers (PCCJPO), do not believe the youth are necessarily receiving any better service as a result and are concerned that overall state costs may actually increase.

JCJC officials believe strongly that the court's ability to place the juvenile must remain intact. The courts need to be assured that, regardless of who pays, the service will continue as long as the judge who ordered the service believes it necessary. DPW issued an ICSI bulletin in June 2005 that affirms that the Juvenile Act confers authority on the juvenile court to enter dispositional orders that are directed to dependent and delinquent children and further states that the ICSI is not intended to and will not interfere with the court's authority to enter such orders. According to DPW, one of the guiding principles of ICSI is to provide children who are alleged or adjudicated dependent or delinquent with timely access to behavioral health treatment services. Court-ordered services for which Medical Assistance funding is not available will continue to be reimbursed consistent with the child welfare funding program.

Corrective Actions by DPW

In response to the above concerns, DPW has taken certain actions to improve communications and ICSI implementation among state, county, and stakeholder groups. The OMHSAS Deputy Secretary acknowledged that DPW did not bring in all of its partners at the start of the initiative and that the Department could have done a better job of sharing the goal of the initiative with those who are impacted.

Specifically, DPW issued ICSI Guidelines and conducted ICSI Guidelines training in 2005, and in July 2005, published an ICSI Bulletin. An amended HealthChoices payment methodology was submitted for approval to CMS and individual county approaches were developed (DPW has a consultant working with individual counties on an as needed basis to help them transition their programs). Also in July 2005, and again that November, the Department published advice to the counties in the form of a series of answers to frequently asked questions. The Department conducts monthly conference call meetings with stakeholders to discuss the status of implementation and issues that have arisen and has established an ICSI steering committee that includes provider and parent membership.

In September 2005, the Department issued a written response to questions regarding the use of both Medical Assistance and child welfare funds to pay for services in an MA-enrolled residential treatment facility. In this response, DPW stated that federal MA funds may only be used to pay for "treatment" or "medical" services and federal child welfare funds are available only to pay for "placement maintenance" costs. If a service is "treatment" for one child for the purpose of drawing down MA funds, it cannot be "non-treatment" for another child for the purpose of drawing down child welfare funds. If, however, one set of children is receiving behavioral health treatment services and another set is receiving "straight" child welfare services, it is permissible to draw down federal MA funds for the former and federal child welfare funds for the latter.

DPW's response further noted that both federal MA and federal child welfare funds may pay for services provided to different children if the RTF provides both treatment and non-treatment service packages as long as MA funds are used only to pay for treatment services for one group of children and child welfare funds are only used to pay for placement maintenance services to another group of children. In those RTFs that have only treatment beds, DPW permits the use of state child welfare funds to pay for services after RTF services are no longer medically necessary to allow for and to facilitate discharge planning or compliance with a court order.

IV.D. The "MA Loophole" Qualifies Children for MH Services Based on Their Income and Not Their Family's Income, But Its High Costs Generated a Controversial Family Premium Payment Initiative

Families of children with serious mental, behavioral, or emotional disorders are often unable to obtain the specialized and intensive services their children need through their private insurance policy or by paying out-of-pocket. Medicaid provides the range of services that children with disabilities require and can be a key resource for these families. However, many such families have incomes too high to be covered under normal Medicaid rules.

Pennsylvania is one of a majority of states that provide Medicaid eligibility to people who meet the disability definition as defined by the standards set forth for Supplemental Security Income benefits. The Social Security definition of disability is generally that (1) the child must have a physical or mental condition(s) that very seriously limits his or her activities; and (2) the condition(s) must have lasted, or be expected to last, at least one year or result in death.

Pennsylvania is the only state that allows a child who meets the SSI definition of disability to be eligible for Medical Assistance without considering the parent's income.[1,2] As a result, annual family incomes for such MA eligible children include all income ranges. Eligibility is based solely on a child's disability or medical condition as per SSI, which is frequently referred to as the "loophole," or Category PH 95, under the Medical Assistance Eligibility Handbook.

Act 1998-150 requires health insurance issued to groups of 50 or more employees to provide coverage for serious mental illness.[3] The coverage shall be for a minimum of 30 days inpatient care and 60 days outpatient care annually, and neither the annual or lifetime dollar limits in coverage for serious mental illness can be different than for any other illness. According to the Department of Public Welfare (DPW) officials and stakeholders, the behavioral health diagnoses most common for children, such as oppositional defiance disorder, are, however, not covered diagnoses. Medical Assistance, on the other hand, has the broadest coverage of medical and mental health services for persons under age 21 of any insurance plan, according to the Pennsylvania Health Law Project. Moreover, private insurers impose

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[1] According to a DPW official, a change in Pennsylvania's Medicaid eligibility requirements in 1988 permitted the exclusion of parental income when determining Medicaid eligibility for a child with a disability. Pennsylvania's requirements for the child are in accordance with an approved State Plan amendment using §1902(2) Social Security Act provisions that allow states to use less restrictive methods to determine eligibility for a specific group of individuals.

[2] The child must not be working and earning more than $860 a month (limit for 2006).

[3] The act specifically lists schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depression disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizoaffective disorder, and delusional disorder.

lifetime benefit limits, but there is no lifetime benefit limit imposed by Medical Assistance.

As of April 2006, DPW reported there were 37,782 "loophole" children in Pennsylvania. Estimates of state spending for loophole children range from $453 million (using the average cost of $12,000 per child as stated in HR 490) to DPW's estimate of approximately $375 million annually. By comparison, other states average between 2,000 and 4,000 children in this special category of care, according to DPW.

Act 2005-42 and Premium Payments

Act 2005-42, as part of an overall effort to control MA costs, made omnibus amendments to the Public Welfare Code that attempted to address some of these concerns over the costs of loophole children. Premiums and co-payments for families with incomes greater than 200 percent of the federal poverty guidelines were one of the strategies identified in this act.

Specifically, section 447 of the act states that custodial parents of a child who is under the age of 18 and disabled shall be required to verify their income as a condition of eligibility of the child. Section 454 further states that families whose income is over 200 percent of the federal poverty guideline and who have disabled children receiving MA benefits will be responsible for premiums and co-payments. The act requires DPW to promulgate regulations to determine premium requirements, benefit packages, co-payments, and effective date for provider payment rates.

The proposed premiums are just one of several cost saving initiatives that include changes to prescription drug co-pays, limiting physician visits and hospitalizations, and limiting provider rate increases. According to DPW, the goal was to save approximately $10 million.[4]

Department of Public Welfare Proposals

The Secretary of Public Welfare, in testimony before the House Health and Human Services Committee in October 2005, stated that cuts in federal funding, the rapidly increasing cost of health care, and an aging population compelled the Commonwealth to pursue various cost containment measures for its Medical Assistance programs. She further told the Committee that "the application of a sliding scale Medical Assistance premium for families whose children receive MA services and whose income exceeds 200 percent of the federal poverty level . . . was necessary as part of an overall effort to continue to deliver services to all those currently

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[4] The approved FY 2005-06 budget included an $11 million reduction in state funding in the Medical Assistance budget as a result of the decision to charge this premium.

eligible in an increasingly dire budget environment." DPW has not favored implementing approaches used in certain other states to deal with Medicaid costs by restricting eligibility enrollments and discontinuing services.

DPW estimates that the Commonwealth will spend over $400 million in FY 2005-06 on the children of families in this category of care. Of these families, DPW has determined that 58 percent have annual incomes of $40,000 or higher. Therefore, under the proposal currently before the Centers for Medicare & Medicaid Services (CMS), 42 percent of the families now receiving services will not have to pay premiums. Of the families that will be asked to pay a premium, DPW has stated that 83 percent will pay less than $100 per month (or less than 1.26 percent of income) to receive an average of $1,000 in services per month.

As can be seen in Table 14, the proposed premium fee scale is adjusted for family size (larger families pay less). Families with more than one loophole child are required to pay only one premium. No premium is to be higher than the average monthly expenditure that DPW pays for services for loophole children, which is currently $1,000. Family income will be reevaluated annually.

DPW also estimates that about 65 percent, or 25,000 of the 38,000 families in this category of care, have some degree of private insurance usually purchased through their employer. The MA premium would be in addition to what they are currently paying for private insurance. In many cases, families are using MA to bridge the gap between services and pharmaceuticals offered by private insurance and the total needs of their child.

Pennsylvania's "loophole" premium would not be the first public program to institute a premium copay requirement based on family income. The Children's Health Insurance Program (CHIP) has a premium copay requirement based on family income. CHIP provides health insurance for children of working families, who otherwise could not afford it, is designed so that families with incomes of less than 200 percent of the Federal Poverty Income Guidelines (FPIG) qualify for free CHIP for their children, and those over 200 percent FPIG may pay a premium for their coverage. As of June 2005, the average CHIP premium was $131, so families that qualify for the low cost CHIP would contribute about $66 per month for coverage.

The FY 2005-06 budget included an additional $10 million to help lessen the financial impact of the premiums on families. The $10 million contribution effectively allowed DPW to reduce the majority of the premiums to half of what they were in the original premium proposal.

Table 14

Medicaid for Children With Special Needs Proposed Monthly Premium

Parental Annual Income (000)	Family Size							Each Additional Member
	2	3	4	5	6	7	8	
$ 0 - $ 39	No premium if income is below 200 percent of federal poverty income guidelines.							
$ 40 - $ 49	$ 30	$ 29	$ 27	$ 26	$ 24	$ 0	$ 0	$ 0
$ 50 - $ 59	40	38	36	34	33	31	0	0
$ 60 - $ 69	50	48	45	43	41	39	37	0
$ 70 - $ 79	60	57	54	51	49	46	43	0
$ 80 - $ 89	75	71	68	64	61	58	55	(3)
$ 90 - $ 99	100	95	90	86	81	77	73	(4)
$100 - $109	150	143	135	129	122	116	111	(5)
$110 - $119	200	190	181	171	163	155	148	(7)
$120 - $129	250	238	226	214	204	193	185	(8)
$130 - $139	300	285	271	257	244	232	222	(10)
$140 - $149	350	333	316	300	285	271	259	(12)
$150 - $159	400	380	361	343	326	310	297	(13)
$160 - $169	475	451	429	407	387	368	352	(16)
$170 - $179	600	570	542	514	489	464	442	(22)
$180 - $189	675	641	609	579	550	522	497	(25)
$190 - $199	800	760	722	686	652	619	588	(31)
$200 - $249	925	879	835	793	753	716	679	(37)
$250 - $299	1,000	950	903	857	815	774	739	(35)
$300 +	1,000	950	903	857	815	774	739	(35)

Source: 55 Pa. Code Ch. 140, Special MA Eligibility Provisions, Appendix B.

DPW published final regulations at the end of 2005 to implement Act 42.[5] A request for a waiver pursuant to section 1115 of the Social Security Act was submitted to CMS. A waiver is required because federal law does not otherwise allow states to collect premiums for children who are determined Medicaid eligible. The regulations become effective 30 days after receipt of notice of the granting of the waiver.

CMS responded to Pennsylvania's proposal in December 2005 by requesting additional information. The request for over 80 items included questions as to what other options DPW considered (such as co-payments or other cost sharing), services available and the number of children receiving each service, how HIPP would be coordinated with this waiver, whether those in the Fee-for-Service system would pay the same premium as those in HealthChoices, what specific measures will be

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[5] Act 2005-42 exempts the department's regulations from review under the Regulatory Review Act, review by the Attorney General under section 205 of the Commonwealth Documents Law and section 204(b) of the Commonwealth Attorneys Act.

considered for evaluation of waiver, and an explanation of how the $11 million in savings for FY 2005-06 and the $14 million in savings for FY 2006-07 were calculated. As of May 2006, DPW was finalizing its draft response to CMS, and officials told us they expected to submit it to CMS but not specifically when this would occur.

Concerns Regarding Implementation of Medical Assistance Premiums

Lack of Service/Quality of Service

Parents of PH-95 children have expressed several concerns about the implementation of a premium. For example, one parent suggested that DPW has not sufficiently assessed the immediate or long-term social and financial impact of this change in policy on families, taxpayers, and public institutions. He noted that, under Medical Assistance, services are provided based upon diagnosis and need; but under the premium proposal, the criteria are family size and gross income. If a family cannot afford the monthly premium, the child becomes ineligible for services and will be dropped from Medical Assistance.

Another parent stated that just because a family is in the MA system and has made arrangements for services does not mean they are actually receiving them. This, in part, is because services are not always available in a timely fashion and when needed.

The Director of AutismLink sees no direct correlation between the amount of services provided and the amount proposed to be charged for the premium. She commented that the majority of families in Pennsylvania's behavioral health system have hours of therapeutic staff support that were prescribed, but are not being filled. Further, families are being asked to pay without any accountability for quality, and families must pay these premiums prior to knowing if they qualify for the services sought, or even if they will be permitted to use the services.

Another specific concern is that families may drop children from their primary insurance and rely on Medical Assistance for exclusive coverage. If this were to happen, it could increase the costs to the Medical Assistance program.

Premium Pay Impact on School-Based ACCESS Program

School districts throughout the Commonwealth use a form of Medical Assistance known as the School-Based ACCESS Program to draw down additional funding for special education. These federal funds are only available to districts if the special education student participates in Medical Assistance and the parents grant permission. By long-standing practice, special education students have been eligible for Medical Assistance coverage. Districts have therefore encouraged parents to apply for this assistance for their child in special education. Pennsylvania school districts reportedly obtained $82 million in additional federal funds for the School-Based ACCESS Program in FY 2003-04.

Under this program, school districts that provide specific physical health services to students with disabilities pursuant to the students' IEPs are eligible for reimbursement. School districts are eligible to have 58 percent of their costs reimbursed from Medicaid (Pennsylvania's federal participation rate), and the remainder is paid by the districts.

The primary concern identified by the School Boards Association with respect to the loophole premium pay initiative is that it will likely result in many families dropping Medical Assistance coverage, which helps pay for "wraparound" services to support the child in school and beyond the school day. While the school may continue to provide the service in school, the service will not be provided outside of school unless the parents pay the Medical Assistance premium. Under IDEA, nonpayment of the monthly premium does not eliminate the school districts' responsibility to provide services. Based on records from the 2004-2005 school year, the ACCESS program generated $22.6 million in federal revenue from the 8,622 loophole students who would be subject to premiums. This revenue would be lost if a parent chooses not to pay the premium and drops the child's MA coverage.

A portion of wraparound services typically occurs in the school in the form of Therapeutic Staff Support (TSS). A family's inability or refusal to participate in the MA premium would result in the district having to replace the existing TSSs and creating a new expense for the district. According to the School Boards Association, this new expense would then most likely need to be covered by an increase in taxes because of capped special education dollars to the districts. The Association reports that school districts cannot simply absorb the lost reimbursement payments without negative fiscal consequences or impacting the education programs for other students. Without family participation in the state plan, local education agencies face a cost shift of more than $260 million, according to the Pennsylvania Association of School Business Officials. As one parent noted, if school districts lose this funding, it could result in families paying two insurance premiums and increased school taxes.

Certain stakeholders suggested that DPW establish a copay based on the amount of services actually provided, with monthly limits on total out of pocket costs based on income (with full deduction for other health insurance premiums and other medical/behavioral health expenses) and family size rather than a monthly premium.

Legislative Actions to Curtail Medical Assistance Premiums for PH-95 Children

House Resolution 490. The resolution urges the Governor to direct DPW not to implement premiums and co-payments for families of disabled children. It was adopted by the House on November 14, 2005, by a vote of 195–0.

According to the resolution, 38,000 PH-95 children receive MA services at an average annual cost of $12,000 per child. MA provides these children services not readily available through private pay or a private insurance policy. Many families use MA eligibility and services to bridge the gap between services and pharmaceuticals offered by their private insurance and the actual needs of the PH-95 child. School districts are eligible for MA reimbursement for a portion of their costs for providing approved medical services to these children enrolled in special education classes.

DPW's approach requires families having incomes greater than $40,000 to pay a monthly premium based on a sliding fee scale to maintain MA enrollment. The resolution suggests that families unable to afford the monthly premium may be forced to discontinue enrollment in the MA program with the potential consequence of a child not receiving needed specialized services. The resolution further suggests that if a family decides to discontinue MA for the child, it will result in reduced federal funding for school districts and potentially increase local taxes to cover loss of revenue for IEP services currently provided through the school district.

PH-95 enrollees, according to the resolution, are entitled to have access to an appropriate education and the specialized services necessary to remain in their homes, participate in their neighborhood schools, and achieve their full potential as citizens of this Commonwealth. Therefore, the House urged the Governor to direct the Department to rescind the plan to implement cost sharing for continued MA services by imposing monthly premiums based on family income for PH-95 category recipients.

House Bill 2246. The bill, introduced November 22, 2005, amends Act 2005-42 by deleting those provisions directing DPW to establish a premium for families with disabled children. On December 7, 2005, the bill passed the House by a vote of 187–0, and on December 12, 2005, was referred to the Senate Public Health and Welfare Committee. As of May 2006, the bill was still with the Senate committee.

IV.E. Controls to Assure That Children's Mental Health Services Are Actually Delivered Should Be Strengthened

The Commonwealth has a variety of efforts to curtail Medicaid fraud and abuse. During the study, however, certain parents expressed concern over the adequacy of the controls in place for certain services, such as TSS, to ensure that providers are actually providing the services for which they are seeking reimbursement.

DPW Efforts to Achieve Accountability

To help ensure compliance and accountability in the Medical Assistance (MA) Program, DPW has established the Bureau of Program Integrity, which conducts investigations, and analysis, and determines the appropriate course of action for all reported instances of fraud or abuse within the MA Program. The Department delineates examples of fraud as:

- Falsifying Claims/Encounters.
- Administrative/Financial.
- Recipient Fraud and Abuse.
- Abuse of Recipients.
- Denial of Services.

To aid in addressing these fraud issues, the Department has established an MA Provider Compliance Hotline, housed under the Bureau of Program Integrity, which allows for the easy reporting of suspected fraudulent and abusive practices by providers of Fee-for-Service and managed care within the MA Program. Additionally, payment for TSS services cannot be made prior to an approved service plan, and services provided before a service plan is adopted are not reimbursable through MA (provider program service descriptions must be approved by DPW).

Bureau of Program Integrity

The Bureau of Program Integrity (BPI) operates under federal mandate within the Office of Medical Assistance Programs (OMAP) to help protect the MA Program from provider fraud, abuse, and waste; to ensure that Medical Assistance recipients receive the medical services paid for; that Medical Assistance recipients do not abuse their use of medical services; and to ensure that feedback is provided to the Department to enhance program performance. The BPI is responsible for preventing, detecting, deterring, and correcting fraud, abuse, and wasteful practices by the providers of Medical Assistance services, including managed care organizations (MCOs), applying administrative sanctions, and referring cases of potential fraud to the appropriate enforcement agency.[1] This includes:

- evaluating services rendered by medical providers and MCO provider networks,
- monitoring recipient overuse and abuse, and
- maintaining ongoing working relationships with federal and state enforcement agencies involved in monitoring potential health care fraud and abuse.

Provider Reviews by BPI. A review of a provider by BPI can be initiated for reasons such as complaints, referrals, and tips, information received by the MA Provider Compliance Hotline, from fraud detection technology, or through random selection by BPI. All providers are subject to being audited by BPI, and these reviews can include:

- claims profile reviews to identify those providers/recipients whose billing/service patterns indicate overutilization or underutilization of services;
- on-site visits to observe the treatment setting, interview staff and providers regarding record-keeping and billing procedures, and/or to obtain records for review;
- recipient evaluations or interviews at centralized locations, or home visits to evaluate services rendered in comparison to services billed; and
- recorded reviews by medical professionals, including peer review, to determine if records are properly maintained, reflect services rendered, services meet required standards or practice, and services are billed appropriately.

The BPI makes a determination whether billing, recordkeeping, or other conduct on the part of the provider has violated MA regulations or standards and will then pursue appropriate remedial action. Those actions will generally include one or more of the following:

- issue discrepancy letters;
- recover improperly paid funds, with or without a penalty attached;
- terminate a provider's provider agreement and preclude a provider's direct and indirect participation in the MA program;
- refer a case to the Attorney General's Medicaid Fraud Control Section (provider fraud), State Office of Inspector General (recipient fraud), or other appropriate criminal law enforcement agency;
- refer a case to an appropriate civil agency, such as licensing bodies;
- seek a civil monetary penalty amounting to twice the overpaid amount plus interest;
- request a corrective action plan or compliance plan; and
- request a provider perform a self audit.

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[1] In addition to the accountability efforts of the BPI, and the self-reporting measures that providers are encouraged to take, all providers are required to meet certain licensing requirements in order to provide services in the state.

DPW reported to us that BPI does not separate the complaints they receive based on funding source. Thus, we were unable to determine the number of complaints directly related to provider fraud in the MA Program. Of the reported incidents, roughly 10 percent are forwarded to the Medicaid Fraud and Control Section of the Attorney General's Office for the pursuit of criminal charges, according to DPW officials.[2] The BPI was able to supply us with data relating to the number of complaints that they receive on an annual basis, but as indicated, does not break these down into specific categories (see Table 15).

Table 15

DPW Medical Assistance Complaints Received

CY	Children's Behavioral Health Outpatient Complaints	Total Behavioral Health Outpatient Complaints	Total Complaints
2003	20	28	270
2004	75	90	218
2005	35	44	240
2006 (As of April)	8	8	29

Source: Department of Public Welfare's Bureau of Program Integrity. Please note that the total complaints column captures complaints about all/any services under MA.

Self-Reporting Requirements

DPW and BPI require providers to self report any overpayment of MA funds that they receive. DPW has issued to providers the "Pennsylvania Medical Assistance (MA) Provider Self-Audit Protocol" as a means of establishing a formal mechanism for providers who discover instances of overpayment or improper payment to voluntarily come forward and disclose the circumstances.

The self-reporting protocol also encourages MCOs under contract with the Department to educate their network providers about the self-audit protocol and encourage all providers to use it. Additionally, DPW recommends that providers conduct periodic audits to identify instances where services reimbursed by the MA Program are not in compliance with the MA Program requirements. Following the self-audit protocol is voluntary and does not alter the requirements of the Single Audit Act or other independent audit requirements.[3] When an MCO reports an

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[2] Created in 1978 in response to Section 17 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142), the Medicaid Fraud Control Section (MFCS) of the Office of the Attorney General has original jurisdiction to prosecute and investigate Medicaid fraud as well as to investigate crimes that arise out of the activities of the MFCS. The main focus of Medicaid fraud investigations by the MFCS concerns providers, which are usually physicians, dentists, mental health clinics, drug and alcohol clinics, hospitals and health maintenance organizations. Recipient fraud is generally left to local district attorneys to prosecute.

[3] The Single Audit Act of 1984, and its subsequent amendments, requires a single coordinated audit of the entire financial operation of an auditee receiving funds from any federal financial assistance program such as the MA Program.

overpayment to the Department, their capitation rate is adjusted, and the necessary reimbursement is submitted to the Department. An official within DPW reports that they are not aware of any significant issues with the self-reporting procedures.

Service Assurance Pilot Project

In May 2006, the Department reviewed proposals for an automated system that could capture time, service, and scheduling information about home and community-based consumer service visits. Such a system could aid in identifying emergency back-up care needs, collecting data for a formal back-up system, and allowing workers to easily report information about the supports and services they provide to clients. These tools, among others that the system will provide, are designed to meet the needs of ensuring quality assurance and provider accountability, by ensuring that home care workers who bill the Medical Assistance Program for services log-in (via phone) at the commencement of the service and log-out at the conclusion of the visit. While the pilot system implementation will primarily involve Pennsylvania Department of Aging (PDA) waiver providers and home health service providers, a small number of behavioral health rehabilitation service (BHRS) providers are involved in the pilot. Upon review of the pilot results, the system may be expanded to include a larger number of providers.

OMHSAS HealthChoices Monitoring

To address accountability and quality in the behavioral health component of HealthChoices, OMHSAS conducts reviews of each county's managed care program. OMHSAS initially performed annual contract compliance reviews, and these have expanded to include assessment of access, quality, and cost-effectiveness. The process includes a desk review, a clinical record review, and on-site interviews with county and behavioral health managed care organization staff.

Performance is reviewed against 31 standards, including state and federal managed care requirements, that fit into four categories:

- Readiness Review Standards for new managed care implementations to ensure basics are in place;
- Policy and Procedures for new managed care implementations to ensure that policies and procedures are consistent with contractual requirements and that any changes are reviewed and approved by OMHSAS;
- Annual Review Standards which are those that OMHSAS has determined need to be reviewed every year to track progress of the plans; and
- Triennial Review Standards which are those that OMHSAS has determined need to be reviewed every three years (most standards are triennial standards).

Findings of reviews are used to improve access, quality, and cost-effectiveness. Findings also result in the development of corrective action plans which OMHSAS monitors.

MA Providers Are Required to Take Certain Precautions Against Fraud

DPW regulations, 55 Pa. Code §1101.51, cite the responsibilities and obligations of providers that receive funds through the MA Program. Providers and MCOs are not only required to adhere to the applicable sections of the Medical Assistance Manual, they are also required to follow the licensing requirements, regulations, and policies that are set forth from DPW.

Medical Assistance Manual

The Medical Assistance (MA) Manual contains numerous requirements that are intended to prevent fraud and abuse within the MA Program. All groups receiving money through the MA Program are required to follow these requirements, which include general provisions as well as provisions specific to certain types of providers.

Among the MA Manual's requirements, providers must maintain records for four years that disclose the nature and extent of services rendered to MA recipients. Providers are also required to make those records readily available for review and copying by state and federal officials, and must submit their cost reports within 90 days of notification that they are being audited. Failure to keep accurate records available for review can result in the termination of the provider's written agreement with DPW for noncompliance, making the provider ineligible for the MA Program.

The MA Manual also requires all participating providers to follow specific procedures for submitting requests for payment and reimbursing for overpayment, and enumerates prohibited acts for providers. The guidelines set forth in the MA Manual direct the interactions between DPW, MCOs, and individual providers within the MA Program and are the basic requirements for contracts between these organizations.

Provider Agreements/Contracts

All MA providers have an agreement with DPW. Additionally, providers in a managed care network have a contract with an MCO. MCOs are required to include specific provisions in any agreements that they enter into with providers. These agreements require providers to follow all applicable laws and regulations and meet all of the requirements of the agreement between the MCO and DPW. Other provisions require a mechanism to suspend or revoke a license or impose other sanctions if performance is inadequate, that records be maintained, and that the provider make all documents available for review, evaluation, or audit by state or federal agencies.

Some providers have established a corporate compliance program designed to achieve various objectives such as ensuring proper training, drafting a code of organizational ethics, identifying high risk areas, and implementing a corrective action plan to control fraud and abuse.

Encounter Forms

According to MA Bulletin 01-95-01, billing procedures for Medical Assistance require that all invoices for services contain a recipient signature. The purpose is to certify that the recipient received the service from the provider indicated on the invoice. If the provider cannot obtain the recipient's signature on an invoice, that signature can be obtained on an encounter form (See Appendix L for form MA-91 "Encounter Form"). These forms act as a verification that a service was delivered on the date specified. The MA Bulletin further indicates that a parent, legal guardian, relative, friend, or legal custodian can, but does not need to, sign an invoice or encounter form on behalf of a child receiving services. The Bulletin does not specifically restrict a minor of any age from signing the form without an adult signature.

Concern was noted by parents of children receiving services that it is inappropriate for children under the age of 18 to sign encounter forms or invoices because such children may be incapable of understanding what they are signing, may be unwilling or unable to challenge the provider, or may not recognize the value of the validation. An official within the Department advised us that due to the ability of a child 14-17 years old to receive mental health services without parental consent or knowledge, the Department cannot require another signature in those cases, if the parent has not consented to the treatment.

V. Additional Gaps and Availability Concerns in Mental Health Services for Children and Youth

As a result of our reviews, questionnaires, and field visits, we identified several other issues and concerns with the children's mental health system in Pennsylvania. We surveyed county MH/MR administrators, C&Y administrators, and chief juvenile probation officers, and asked them to tell us what the most pressing issues and concerns are with the juvenile mental health system. Additionally, we met with a variety of stakeholders, including providers, parents, families, advisory groups, and advocates to hear their concerns regarding gaps in services within the current system.

Availability and Timeliness of Children's Mental Health Services

Availability of Services

When assessing the availability of services in their counties, MH administrators responding to our questionnaire (38 out of 46) indicated that services are generally available for children and youth in their county. For example, roughly three-quarters or more of the respondents reported that most services were either usually or almost always available when needed (see Table 16).

Table 16

Availability of Mental Health Services for Children and Youth

	Never/Almost Never Available When Needed	Often Not Available When Needed	Usually Available When Needed	Always/Almost Always Available When Needed
Inpatient	11%	11%	39%	39%
Residential	16	13	61	11
Partial Hospitalization	3	5	55	37
Outpatient	0	16	53	32
Family Support[a]	0	24	45	18
Overall Average Per Response	5	14	51	27

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[a] Thirteen percent of respondents were either unclear or chose not to respond to our inquiry into the availability of family support services for children and youth in their county. Total number of responses = 38.

Source: LB&FC staff questionnaires to MH/MR administrators.

According to one MH/MR director, there are capacity issues with certain specialized services. Community Residential Rehabilitation (CRR) is, for example, a step-down service from Residential Treatment Facilities (RTFs). A limited pool of families exist who are willing to take these children in their homes, and there is competition for them because children and youth agencies also use this service. Capacity for this service is especially limited for children with more severe problems, such as fire starting or sexual issues. Placement can take up to two months for such youth.

Capacity in mental health facilities has become a larger issue since the advent of managed care, according to the Pennsylvania Community Providers' Association. Under managed care, rates tend to be lower, so providers now maintain full schedules, leaving no room for last minute appointments or emergencies, which in turn yields little or no excess capacity.

System capacity is also an issue for the Psychiatric Hospital Association (PHA). According to the Association, a lack of beds in local RTFs and "step down" programs is a problem. This can lead to clients remaining in psychiatric facilities longer than necessary, thus keeping the youth in a more expensive treatment environment. The PHA members also noted that multiple other factors can result in extended lengths of stay, such as RTFs being reluctant to admit certain types of clients (e.g., potential suicides) and parents being resistant to having their children released from inpatient care.

We also discussed capacity issues with an official of the HealthChoices managed care organization in Philadelphia. The official noted that the facilities represented by the Psychiatric Hospital Association sometimes have empty beds, especially over weekends, and deny admissions from patients covered by HealthChoices. According to the official, in her opinion this is because these facilities are not fully staffed over the weekends and that they may, as a matter of practice, prefer to hold beds for patients covered by private insurance.

Timeliness of Services[1]

Problems with providing various mental health services in a timely manner were also reported to us throughout this project. MH/MR and children and youth administrators cited waiting lists for services as a problem in their responses to our questionnaires. One frequently cited cause of waiting lists is a statewide need for more child psychiatrists (discussed below). One county C&Y administrator noted that, due to the lack of psychiatrists, there can be a three to six months wait for an appointment. Another cited a delay of three to four months for psychiatric evaluations. Several county MH/MR administrators noted that the need for mental health services in their counties has grown faster than the availability of services, leading

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[1] See Chapter IV.B for a specific discussion of timeliness of wraparound services.

to delays in providing those services. Counties do not, however, maintain information on the specific delays encountered when seeking these services and, therefore, no data is available regarding the actual length of delays incurred or the cause of those delays.

The child advocacy group, Philadelphia Citizens for Children and Youth (PCCY), conducts monthly surveys of providers that deliver outpatient behavioral health services to children on Medicaid to determine the wait times for mental health services from these providers. For 2005, PCCY reports that the average wait time for an intake interview was 21 days, the average wait time to see a therapist was 20 days, the average wait time to see a psychiatrist was 75 days, and an average of 6 providers were not accepting new patients at the times the surveys were conducted. These are average wait times, and in some instances the reported wait times were as much as three months (or in the case of psychiatrists – eight months). The times presented on Table 17, calculated by PCCY are similar to the anecdotal information reported to us through questionnaires and interviews.

Table 17

Average Wait Times for Assessing Children's Mental Health Survey
(Philadelphia)

	Average Wait	Range
Intake Interview	21 days	14 – 90 days
Therapist Appointment.......	20 days	15 – 90 days
Psychiatrist Appointment ...	75 days	0 – 240 days

Source: Philadelphia Citizens for Children and Youth.

The Department of Public Welfare (DPW) has certain standards for services in managed care counties. In its HealthChoices contracts, DPW requires that managed care plans provide face-to-face treatment intervention within one hour for emergencies, within 24 hours for urgent situations,[2] and within seven days for routine appointments and specialty referrals. DPW does not directly monitor these requirements, but does participate in assessments of the HealthChoices plans that includes a review of these timeliness requirements. HealthChoices also has a complaint and grievance process that must comply both with the general guidelines for managed care organizations as well as with federal rules under the Medicaid State Plan approved by the federal government and special conditions set forth by OMHSAS.

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[2] "Urgent" is defined by the contract as "any illness or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or emergency situation. Additionally, it includes situations such as when a member's discharge from a hospital will be delayed until services are approved or a member's ability to avoid hospitalization depends upon prompt approval of services."

Gaps in Services

Table 18 identifies the key gaps reported through our questionnaire process. The lack of psychiatric services was noted most often as a gap by children and youth and county juvenile probation officers, and mentioned second most often by MH/MR administrators. Other significant concerns were lack of transitional services and lack of services for co-occurring disorders. We also used information obtained from interviews and field visits with county officials, providers, and other stakeholders to identify other areas of concern as discussed below.

Table 18

Reported Gaps in the Mental Health Service Delivery System for Youth and Adolescents

Gap/Issue	MH/MR Administrators Questionnaire N=38	C&Y Administrators Questionnaire N=27	JCPO Questionnaire N=38
Transitional Services	60.5%	15.4%	18.4%
Psychiatric Services	47.4%	38.5%	31.6%
Interagency Collaboration[a]	31.6%	7.7%	26.3%
Training and Staffing	44.7%	38.5%	13.2%
BHRS Issues, Especially TSS	36.8%	7.7%	7.9%
Educational Services, Including Partial Hospital Settings	15.8%	7.7%	0.0%
Family Involvement[b]	13.2%	11.5%	13.2%
Outreach Efforts and Resource Information	2.6%	11.5%	2.6%
Step Down/ Aftercare Services	5.3%	7.7%	7.9%
Other Specialized Services[c]	86.8%	69.2%	63.2%
Funding	39.5%	38.5%	5.3%

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[a] Please see Chapter III.A for discussion on this issue.

[b] Please see Chapter III.B for discussion on this issue.

[c] Specialized services include: deaf and hearing impaired, sexual offender treatment, services for Autism, and especially co-occurring treatment issues.

Source: Responses to LB&FC staff administered questionnaires.

A. Psychiatric Services

The lack of psychiatric services, particularly child psychiatrists, is the concern we heard most often in our interviews and field visits. In fact, one half of our MH/MR administrator questionnaire respondents report the lack of psychiatric services as one of their top issues and concerns. The literature suggests that this gap is a nationwide phenomenon, due to the length of training required for child psychiatrists combined with the relatively low reimbursement rates for these services. Frequently, the lack of psychiatric evaluation services results in time delays for services because a psychiatric evaluation is required prior to beginning service.

In certain cases, a psychiatrist, rather than another medical professional, is needed to conduct the evaluation. For example, federal regulations, 42 C.F.R. §441.153, require that an evaluation be performed by a child psychiatrist for certifying the need for services at a JCAHO facility.[3] Certain officials indicated to us that it may be sufficient for the evaluation to be performed by a psychologist. However, depending on the placement, for example, in a JCAHO-accredited facility, a psychiatrist would be required.

The shortage of child psychiatrists reportedly results, in some cases, in periods of up to six months before a child can meet with a psychiatrist for evaluation of medication. In Philadelphia, the average waiting time for a child to see a psychiatrist is reported to be 75 days, ranging from a same day appointment up to eight months.

We were also told that some child psychiatrists do not accept MA clients due to low reimbursement rates. Numerous county officials and other stakeholders said low reimbursement rates have resulted in an inability to attract and retain child psychiatrists.

In Philadelphia, the managed care entity, Community Behavioral Health, has stopped seeking evaluations from board certified psychiatrists to improve the timeliness of evaluations prior to the child receiving services. Instead, the county uses non-board certified psychiatrists and psychologists, even though Philadelphia has an above average ratio of child psychiatrists per capita. In another aspect of the problem, in Cumberland County, the children and youth office reports having difficulty finding psychiatrists willing to conduct evaluations in large part because they do not want to testify in court.

To address the lack of child psychiatrists, the Governor's Commission for Children and Families has recommended that incentives, such as scholarships or loan forgiveness programs, be offered to train and retain psychiatrists, psychologists, and other mental health workers.

Telemedicine has also been cited as at least a partial solution to the psychiatric shortage. The National Library of Medicine defines telemedicine as the practice of medicine when the doctor and patient are widely separated using two-way voice and visual communication (as by satellite, computer, or closed-circuit television).

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[3] In a JCAHO accredited facility, wherein MA pays for both treatment and room and board, a psychiatrist is required for the evaluation. In non-JCAHO accredited facilities wherein MA pays for treatment only, an evaluation by a psychologist is acceptable.

The American Psychiatric Association, applying this definition to psychiatry, defines it as the use of electronic communication and information technologies to provide or support clinical psychiatric care at a distance. This includes using the telephone, fax, email, the internet, and still imaging and live, interactive two-way audio-video communication. Another author[4] defines it as the use of electronic communication technology to eliminate or reduce geographic barriers to receiving psychiatric services.

According to an April 7, 2006, AP article (see Appendix M), several states, including Pennsylvania, are encouraging telepsychiatry. Greene County is working with its contractor, Value Options, to use telepsychiatry in a pilot program in one of its school districts. The program is not used for initial evaluation, but uses video conferencing, located in the school nurse's office and the psychiatrist's office, for follow-up and medication checks. OMHSAS views telepsychiatry as a promising practice that may help alleviate the psychiatrist shortage, as well as lessening the stigma attached to being under psychiatric care.

Telepsychiatry could be particularly valuable in rural areas where there are few, if any, child psychiatrists. This could become more important as DPW expands HealthChoices to the remainder of counties, which tend to be the more rural. Secondly, telepsychiatry can help children with specialized needs receive services. For example, it can allow a child who is deaf or hard of hearing to get services from a sign-fluent therapist.

Telepsychiatry services can be provided in a variety of settings (school, home, or office); for example, this would allow children to remain in school during the day rather than leaving for an appointment. Telepsychiatry is also flexible in that it can occur between physicians in consultation, between a physician and another care provider, or between the psychiatrist and the patient.

There are also disadvantages to telepsychiatry. According to a Psychiatric Times article,[5] although costs for equipment have come down, payors are reluctant to invest the necessary funds. And there are other caveats to be considered, according the American Psychiatric Association.[6] These issues include: is telepsychiatry as effective as services received face-to-face; are there certain conditions or diagnoses better suited to telepsychiatry; and how does this way of delivering care affect the patient-provider relationship.

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[4] Urness, S. Telepsychiatry. Discussion Paper DP 2003-1. Ottawa: Canadian Psychiatric Association; 2003.

[5] Kanapaux, W. *Psychiatric Times.* Telepsychiatry's Untapped Potential: When Will It Pay to Deliver? Vol. XXII, January 2005.

[6] The American Psychiatric Association (APA) supports the use of telemedicine as an appropriate component of a mental health delivery system to the extent that its use is in the best interest of the patient and is in compliance with the APA policies on medical ethics and confidentiality.

B. Transitional Services for Persons 18-21

The need for transitional services for adolescents aging out of the juvenile mental health system and entering the adult system is a concern we heard from almost all parties with whom we spoke during the course of this study. Approximately 60 percent of county MH/MR directors cited this problem in their surveys. They reported that children "age out" and are simply not prepared for adulthood. For those who have been in residential placement, their parents often do not want them to return home.

Young adults reportedly often do not feel comfortable in treatment settings that are geared toward older adults, such as afternoon drop-in centers, and have difficulty relating to those who are not in their age group. To address this concern, in 2002, OMHSAS funded ($540,000) five pilot projects for transition aged youth. The goal of the projects was to "support the development or expansion of their community's capacity to provide services to transition age youth with serious mental illness or disturbance as they transition into adulthood."[7] In FY 2005-06, funding for these projects was cut by 54 percent due to cuts in Community Mental Health Block Grants; DPW reports that state funding will end as of July 1, 2006. County programs, each receiving $108,000, include:

- ***Delaware and Chester Counties***. The two counties jointly administer the Transition Age Project, serving 14-22 year-old individuals diagnosed with a mental illness or SED. The project has a maximum capacity of 10 participants per county and uses a project team approach (based on an intensive case management model), with the project manager responsible for the initial assessment and developing person-centered plans. The team is responsible for establishing linkages to both children's and adult service providers. The program's focus is on treatment services, housing, education, employment, and disease management.
- ***Allegheny County.*** Allegheny's program serves 18-to-25-year-olds and focuses on two groups: those with new and early onset of psychiatric illness and those who are likely to utilize higher levels of MH services, have repeated out-of-home placements and multiple-system involvement. Seventy individuals/families are served through a community team model. The team uses an enhanced case management model to provide comprehensive services and also provides rent subsidies to assist individuals and families to find housing.
- ***Westmoreland County.*** Westmoreland County's program, Community Outreach through Resources and Education, serves 16-to-24-year-olds with emotional and behavioral difficulties and serves a maximum of 20 individuals at any one time. A transition facilitator helps with job skills, transportation issues, and getting away from their parents. The county has contacts with OVR and

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[7] S. Schoolfield. *Services for Transition Age Youth: How Two Counties Implemented Pilot Project Funding. A CAASP discussion paper, 2005.*

business schools. Approximately 50 young adults have been enrolled in the program over the past few years.

- ***Dauphin County.*** Dauphin County's Joint Efforts Reach and Energize More Youth (JEREMY) project provided a transition coordinator for person-centered planning and implementing the flexible utilization of existing resources.

- ***Clearfield/Jefferson and Dauphin Counties.*** These counties also have transition age pilot projects for which funding will end at the end of FY 2005-06.

In addition, other counties have used their own dollars or HealthChoices reinvestment dollars to fund their own programs. They include Berks and York/Adams Counties.

- ***Berks County.*** Paid for through HealthChoices reinvestment dollars, the Community Treatment Team Model (CTT) for Transition Aged Youth is an intensive, multidisciplinary approach to provide MH services to adolescents in the community and includes a variety of specialists: psychiatrist, psychiatric nurses, D&A clinician, MH clinician, case manager/housing specialist, vocational specialist and a peer support counselor. As of February 2006, the county was seeking DPW approval to have CTT paid for through its HealthChoices managed care in lieu of other services.[8]

- ***York/Adams Counties.*** As of February 2006, this MH/MR county joinder was implementing a transition residential program for aging-out youth to assist them in moving from the children's system to the adult system through intensive case management to help them with life skills and connecting them to other programs, for example, educational or vocational. York/Adams has dedicated approximately $250,000 of HealthChoices reinvestment dollars to start up the program, after which it will be paid for out of county funds. They expect to serve four individuals at any given time.

According to a DPW official, the Department has worked with the counties to develop plans to continue to provide these services and that counties have been innovative in finding alternative funding sources. In addition, in May 2006, the Department hired a "transition coordinator" to help counties with transition services disseminate information, and generally raise consciousness about the transition issue. DPW's Autism Director also reported in May 2006 that the Department plans to provide for a transition coordinator specifically for autistic youth by mid-2006.

C. Services for Co-Occurring Disorders

Mental health services for youth are generally reported to be far more available than drug and alcohol services, primarily because a juvenile may qualify for mental health services under Medical Assistance (see Chapter IV.D regarding the "loophole") but does not qualify for MA services based on drug and alcohol issues

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[8] Individuals in this program would receive the transitional services only, intended to prevent necessity for other more expensive services.

alone. This is because mental illness is considered a disability under the Social Security definition, whereas drug abuse/addiction is not.

Services for co-occurring disorders, where an individual has both a mental health and substance abuse problem, are important because of the prevalence of both among juveniles. The Oregon Adolescent Depression Project (OADP) assessed lifetime comorbidity in 1,710 high school students and reported that 66 percent of adolescents with a substance use disorder (SUD) had an additional lifetime psychiatric comorbid disorder, compared to 31 percent of adolescents without an SUD. In one study of mental disorders in the community, adolescents ages 14-17 years old diagnosed with an SUD were found to be 1.5 times more likely to be diagnosed with an anxiety disorder, 3.7 times more likely to be diagnosed with a mood disorder, and 20.3 times more likely to be diagnosed with a disruptive disorder than adolescents without current SUDs.

DPW and DOH have funded several Mental Illness and Substance Abuse (MISA)[9] service integration pilot projects in Pennsylvania. However, only one, in Berks County, is specifically targeted to juveniles. It is a partnership between the county, Reading Hospital, and the Reading School District that identifies clients through the school's Student Assistance Program (SAP). The project started with intensive outpatient treatment of 6–12 students in group therapy. It has expanded to include MISA-trained therapists and is pulling children out of the other systems--not just the school district.

The project has developed a single assessment for all SAP referrals. MH/MR and Berks SCA have developed joint policies in cooperation with HealthChoices. Community Care Behavioral Health Organization (CCBHO)[10] is a participant in the project and has created incentives for providers to undertake these comprehensive MH and drug and alcohol evaluations of clients entering the program to encourage more efficient and effective use of resources. One problem identified is the need for dual licensing of providers; DPW licenses and regulates mental health providers, whereas DOH licenses and regulates substance abuse providers. Few providers are dually licensed. The county has received notice that there will be no MISA funding beyond June 30, 2006. Without the money, intensive outpatient treatment will be curtailed.

Other initiatives to address co-occurring behavioral health needs for Pennsylvania youth include:[11]

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[9] MISA projects are to demonstrate the potential of specialized mental health and substance abuse integrated treatment and support services as a cost-effective alternative to traditional services and to create best practice models of treatment systems integration.

[10] CCBHO is the behavioral health managed care organization for Berks County HealthChoices.

[11] Pennsylvania has also received a co-occurring state incentive grant (COSIG) from SAMHSA. At the end of the five year grant, Pennsylvania has proposed to have developed a permanent infrastructure for the delivery of co-occurring psychiatric and substance use disorders services.

- The York/Adams counties joinder has a family-based team that specializes in co-occurring disorders, funded through HealthChoices reinvestment dollars. The counties use a provider that is dually licensed to provide services.
- Fayette County is seeking a provider to deliver a specialty family-based MH service that serves families with substance abuse issues. However, the provider has been unable to recruit qualified staff who are willing to do home-based work in a rural area.

Another significant problem identified with treating co-occurring disorders is the difficulty in sharing information due to state and federal confidentiality requirements. As discussed in an LB&FC 2003 report (*Drug and Alcohol Treatment Services in a Managed Care Environment*), Pennsylvania's drug and alcohol confidentiality regulations are significantly stricter than federal requirements.[12] For example, a Philadelphia facility reported to us during the earlier review that it may use two providers to treat the same clients for mental illness and substance abuse, but communication between the different providers is, at least technically, a violation of the confidentiality restrictions.

The issues identified during the LB&FC 2003 review have not changed. Issues concerning the more stringent language of the Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. §1690.101 et seq., the Department of Health regulations under that act, 4 Pa. Code §255.5, and its 1997 letter clarifying the requirements of the regulations in relation to the Pennsylvania Managed Care Act, and the provisions of HIPAA and other federal requirements remain. The 2003 report recommended that if a planned reissuance of the 1997 guidance by the DOH did not resolve the dilemma, the Department consider new regulations to allow, with patient consent, greater flexibility in the type of information that can be disclosed to a managed care organization. As of April 2006, however, no such guidance or regulatory action had been taken.

In response to the report recommendation, the Department of Health convened a stakeholder's group of interested parties to address the differing confidentiality requirements. Although the Department reported some progress in the discussions between providers, payers, program office, and regulators, the Department disbanded the group in late 2004 due to litigation over Act 106 that involved many of the participants.[13] Other efforts have been initiated to coordinate the differences between the drug and alcohol programs. These efforts include DPW's Co-Occurring Disorders Advisory Committee, the Behavioral Health

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[12] The federal requirements do not preempt state laws or regulations, therefore, a more restrictive state requirement regarding confidentiality will take precedence over a less restrictive federal requirement.

[13] Act 1989-106, 40 P.S. §908-1 et seq., requires certain coverage of drug and alcohol treatment services in insurance policies or contracts. Mandated coverage for alcohol abuse treatment services was originally provided for by Act 1986-64, which was amended by Act 106 to extend coverage to include substance drug abuse within the mandate. For non-hospital residential and outpatient services, the act requires that the insured be referred by a licensed physician (or psychologist) to be covered.

Workgroup of OHCR, and the Office of Health Care Reform's evaluation of drug and alcohol services.

As of May 2006, this issue was under review by the Governor's Policy Office, which was in the process of meeting with the various departmental staff and counsel to determine whether changes are necessary to remove the impediments to sharing necessary information require a statutory, regulatory, or policy approach. Reportedly, DPW, DOH, the Governor's Office, and the Office of General Counsel are close to reaching a resolution on this matter. Please see Appendix N for pertinent excerpts from the 2003 report on *Drug and Alcohol Treatment Services in a Managed Care Environment.*

D. Educational Services in Partial Hospital Settings

A partial hospitalization program is a nonresidential treatment program which includes psychiatric, psychological, social, and vocational elements under medical supervision. This program is designed for patients with moderate to severe mental or emotional disorders. Partial hospitalization patients require more intensive and comprehensive services than are offered in outpatient treatment programs. These services are provided on a regularly scheduled basis for at least three, but less than 24, hours in any one day. About 10 percent of respondents to an Education Law Center questionnaire indicated that their partial hospitalization programs are located within school buildings.

Mental health regulations require that the treatment plan for an adolescent partial hospital participant be based on an evaluation that includes an examination of the child's educational situation. However, there is no requirement that the child receive any specific educational services. Pennsylvania's Public School Code also does not specifically address educational requirements for children in partial hospital programs.

Based on a survey conducted by the Education Law Center[14] in 2003, the same problems related to education in partial hospital programs that were identified in a survey in 1998 continue to exist. About half of the programs report providing three hours or less of academic programming per day. Many of the parents surveyed reported that their children were receiving less than this and that their children are not provided the same educational opportunities as in a traditional classroom.

In a report released in March 2004, the Education Law Center addressed concerns about the education provided for children in partial hospitalization programs. The Law Center concluded that there is a lack of state regulation and

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[14] The Education Law Center (ELC) is a non-profit education advocacy organization that works on behalf of educationally "at risk" students. Offices are located in Philadelphia, Harrisburg, and Pittsburgh.

monitoring for the education components of partial hospital programs that serve school-aged children. They recommend that a state level memorandum of understanding (MOU) be developed to ensure educational services for these children. The MOU should identify who is programmatically and fiscally responsible for the children; guarantee compliance with federal law; describe how both the education and mental health program are to be funded; describe how discharge planning is carried out; and identify the state agencies responsible for monitoring the programs.

In an attempt to address the problems of providing educational services for children in partial hospital programs, DPW and PDE formed a joint committee to redesign partial hospitalization protocols relating to admission, transition, and discharge to encourage interagency planning and provide for collaboration with the educational system.

In fall of 2005, this committee recommended that PDE propose the following changes to the Public School Code: (1) designate the child's district of residence as programmatically and fiscally responsible to provide education services to the student; (2) restrict the long-term use of homebound instruction for children in partial hospitalization programs; and (3) require five to five and a half hours of education services to be offered per day.

The committee also recommended that DPW clarify the types of acceptable education arrangements. Other recommendations included that: (1) the Department determine licensing standards for school-based partial hospitalization; (2) PDE and DPW work together to encourage LEAs to obtain licenses and contract with mental health providers for school-based programs; and (3) the departments encourage interagency collaboration between the school districts and counties in all areas of treatment and transition planning.

PDE and DPW jointly sponsored a series of 27 forums throughout the state in March and April 2006. These forums were designed to provide information on these proposed changes and to gather feedback from the various stakeholders. Attendees include representatives from school districts, IUs, county MH/MR offices, private providers, CASSP coordinators, parents, and advocates. Following a presentation on the proposed changes, Department representatives ask those in attendance to identify possible implications, both positive and negative, that they believe could result from implementing these changes. PDE informed us that the attendance at these forums has been good, and they are receiving more positive than negative feedback. In June 2006, PDE and DPW plan to review the positive and negative issues that were identified at the forums. A report highlighting those issues will be developed and issued during the summer of 2006.

E. Respite Care

Many of the groups and counties we spoke to pointed out that respite care is desperately needed, particularly for families who struggle with children with long-term mental health issues. Respite care is not a covered service under federal Medicaid law, unless provided under a waiver—i.e., the failure to cover respite as an MA service is not a choice under federal law. Respite care is covered under several home- and community-based waiver programs. DPW is, therefore, reviewing what other states are doing to determine if any are receiving MA dollars for such services. If so, DPW's intention is to add family respite care as an MA reimbursable service on a limited basis. As with transition programs, some counties are nonetheless providing such services through reinvestment dollars.

- ***Westmoreland County.*** The county's Specialized Program for Alternative Respite Care is based at the YMCA; maximum stay is seven days. The program was originally created to help to take care of children whose parents had to go into the hospital for their own issues--the child would end up in the C&Y system--however, the program can be utilized by parents and families who need a break.
- ***Delaware County.*** In December 2005, Delaware County issued a request for proposal (RFP) to provide respite services for children with a mental health diagnosis. The program is mainly intended for in-home services, however, facility-based respite may be considered. Proposals were due in late January, and the successful bidder was announced in spring 2006.
- ***Fayette***. Fayette County uses reinvestment dollars to pay for respite services for children and families of children ages 10-18 with a mental health diagnosis.

F. Outreach Efforts and Resource Information

Several families with which we had contact cited the lack of outreach and resource information as a significant problem. A report prepared by the Family Training and Advocacy Center, a family advocacy group, states that families often do not know where to go to get help for their children, that schools were not helpful, and that many spent weeks trying to find the proper person. Such concerns were also voiced in LB&FC staff led focus group of families, nearly all of whom reported having difficulty initially accessing the MH system. They stated it was difficult to find out who to contact, how to access the necessary referral mechanisms, and what types of services are available. All of the parents present had received information about how to get help for their children from other parents, at least initially, and not from government agency sources.

Provider groups also believe additional outreach efforts are needed, especially for minority children. According to one group of providers we spoke to, the mental health system usually only finds out about these children after a crisis has occurred, when services become more expensive to deliver. Further, the group indicated that minority groups in particular would benefit if more services could be provided in non-traditional settings, especially homes and schools. Some of the best people to identify children with problems are those in their daily life, according to the group.

The Surgeon General's report on children's mental health referenced earlier, states that the stigma of mental health problems is far greater for minority children and gives some reasons for the disparity, including the cultural competence of mental health providers and lack of outreach and community education programs.

One of the difficulties in improving outreach efforts is finding a source of funds to pay for them, as outreach is not an MA reimbursable service. The Department of Health, however, maintains the Special Kids Network, a free state-wide service that assists families with children with special needs in obtaining services. Calls are answered by an Information and Referral Specialist who is able to access a network of referral resources, including those for social services and counseling; support and advocacy; and therapy services. Representatives of the network pointed out, however, that information and required services are best when provided locally and that statewide programs create too much distance between the service and the client.

The Governor's Commission for Children and Families has issued two recommendations to address outreach and resource issues. Because families often seek the support of others in the same situations, the Commission recommends establishing and replicating successful parent and family models that have helped families find services, helped redesign services, and strengthen policies throughout Pennsylvania. Additionally, the Commission recommends that websites and one-call numbers (e.g., 211) be established so that families can find services in a timely manner.

G. Prevention Programs

Prevention services were identified as another gap in the juvenile mental health system. Funding for behavioral health services has focused on treatment rather than prevention. Prevention programs, however, that have been proven to have results can head off more serious problems in a child's future. Some of the model evidence-based prevention programs listed on SAMSHA's website (see Chapter III.B) are in use in Pennsylvania. For example, the PATHS program is offered in Harrisburg schools through a series of grants. This curriculum, for youth aged 5-12, is intended to promote emotional and social competency and reduce aggression and acting-out behaviors, while simultaneously enhancing the educational process in the classroom. PATHS is also intended to improve a child's self-esteem, self-control, emotional understanding, and self-confidence.

One provider we spoke with uses only evidence-based programs, including PATHS, Nurse Family Partnership, Multisystem Therapy, and Cognitive Behavioral Therapy for Sex Abuse. According to the Washington State Institute for Public Policy, the Nurse Family Partnership Program,[15] which is a prevention program, can save over $17,000 per year per participant. (See Table 19 for additional information on prevention programs as reported by the Institute.)

Table 19

Benefits and Costs of Selected Prevention Programs

Program	Benefits	Costs	Benefits Minus Costs
Adolescent Transitions Program	$ 2420	$ 482	$ 1938
Aggression Replacement Program	15,606	759	14,846
CASASTART	4,949	5,559	(610)
Nurse Family Partnership..................	26,298	9,118	17,180
Scared Straight.................................	(11,002)	54	(11,056)

Source: Washington State Institute for Public Policy report, *Benefits and Costs of Prevention and Early Intervention Programs for Youth,* September 17, 2004.

The Department of Education offers several programs that, while not necessarily prevention programs, do focus on providing early identification and services for students with behavioral health problems. The Student Assistance Program, discussed in Chapter III.A, identifies high risk students and refers those students for services, including assessment. The Early Intervention program (Chapter III.A) identifies and provides services for young children with developmental delays. The Response to Intervention pilot program (Chapter III.B) is designed to enable early identification and intervention for students at academic or behavioral risk. This is accomplished by school-wide screening of academics and behavior for all students in the regular education setting.

The Governor's Commission for Children and Families has stressed an emphasis on prevention and states that solutions must be found to mediate, ameliorate, or lessen the factors that predispose some children to greater risk for developing mental health problems and increase the factors that promote child well-being. The Commission has offered several recommendations to improve the Commonwealth's early intervention and prevention efforts. Exhibit 3 in Chapter III.A shows these recommendations, among others, that the Commission has made.

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[15] The Nurse Family Partnership Program provides intensive visitation by nurses during a woman's pregnancy and the first two years after birth. The goal of the program is to promote the child's development and provide support and instructive parenting skills to the parents.

H. Training and Workforce Shortages

Hiring and Retention of Mental Health Workers and Professionals. County Mental Health and Mental Retardation Administrators noted in questionnaire responses that it is difficult to find qualified candidates to fill the mental health worker positions available in their counties. High turnover rates for mental health workers also contribute to staffing problems and decrease the effectiveness of training programs designed to improve the clinical abilities of the workforce. High turnover is often attributed to low levels of compensation along with the stress of the job. These factors make these types of positions unattractive to workers.

The Governor's Commission for Children and Families has recommended ways to increase the number of professionals who can provide quality services to children experiencing mental health problems as a way to advance children's mental health and well being. Specifically, the Commission recommends providing incentives to state training institutions to have more psychiatrists, psychologists, and other mental health workers trained and retained in Pennsylvania through the use of scholarships and loan forgiveness programs.[16] Additionally, the Commission suggests exploring the possibility of offering housing assistance, college tuition, and other incentives to attract and retain mental health professionals. Such incentives may serve to attract individuals into the mental health field and help alleviate some staffing concerns.

Training Organizations. Training for mental health workers is the primary focus of the CASSP Training and Technical Assistance Institute, as well as the Child Welfare Training Program, the Center for Juvenile Justice Training and Research, and the Pennsylvania Training and Technical Assistance Network, although the latter three of these organizations do not place an emphasis on training mental health workers and offer limited programming related to mental health training.

- ***Pennsylvania CASSP Training and Technical Assistance Institute.*** In 1993, the Pennsylvania CASSP Training and Technical Assistance Institute was founded to implement systematic training of all children's mental health professionals and to act as the training agent for OMHSAS. The CASSP Institute is affiliated with the Department of Psychology in the School of Liberal Arts at Penn State University.

  The CASSP Institute sponsors trainings in clinical best practices, provides technical assistance, publishes and distributes training curriculum, and works with higher education and professional guilds to improve undergraduate, graduate, and continuing education to develop and improve Pennsylvania's mental health professionals. The CASSP Institute

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[16] Senate Bill 413 would create a Mental Health and Mental Retardation Staff Member Loan Forgiveness Program and an Alcohol and Drug Addiction Counselor Loan Forgiveness Program for Commonwealth residents.

receives approximately $600,000 from OMHSAS to provide training to improve the clinical practice of children's mental health workers in the public sector and build capacity in the workforce. In addition to those funds, fees received from trainings add approximately $300,000 to the operating budget each year.

Because of the diversity of the agencies accessing the CASSP Institute's trainings, interagency coordination and cooperation is emphasized in the training programs. Additionally, evaluation forms for the trainings offered are used by the CASSP Institute to assess the impact of the trainings on best practices. The Institute conducts research to determine how well participants acquire clinical skills and the impact of the skills on agency practices and outcomes.

- ***Child Welfare Training Program.*** The Child Welfare Training Program (CWTP) is a collaborative effort between DPW, OCYF, and the University of Pittsburgh's School of Social Work. The CWTP provides training to direct service workers, supervisors, administrators, and foster parents in providing social services to abused and neglected children and their families. Management of the training is performed by the university, with a total project cost of approximately $14.4 million provided by funding from DPW, the University of Pittsburgh, and other sources.

  In May 2005, the CWTP and the Department were notified by federal authorities about concerns regarding the use of Federal IV-E funds for such training purposes. As a result, the CWTP lost $6.48 million in funding for FY 2005-06.

  Due to this reduction of resources, the University of Pittsburgh scaled back operations of the CWTP and closed seven regional training centers in September 2005. The closure of those facilities also resulted in the elimination of certain training programs (those not necessary to the core needs of the child welfare program) that were offered to statewide child welfare workers and a restructuring of the training programs that are currently offered.

  The restructured program may limit the availability of training to private providers. Beginning in 2004, private providers had equal access to training programs offered through the CWTP (at no charge) in an effort to expand participation and ensure cross sector representation in trainings. Due in part to the funding adjustment, however, private providers may only participate in training programs on a "space available" basis after county child welfare workers.[17]

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[17] DPW noted that there have been limited instances where private providers have not been able to access the free training and providers continue to be able to regularly enroll in these courses.

- ***Pennsylvania Training and Technical Assistance Network.*** The Pennsylvania Training and Technical Assistance Network (PaTTAN) is an initiative of the Pennsylvania Department of Education, Bureau of Special Education. It supports the efforts and needs of the Bureau of Special Education and builds the capacity of local educational agencies to serve students who receive special education. This is achieved through three regional offices (Harrisburg, Pittsburgh, and King of Prussia) which develop training courses, offer technical assistance, and provide resources to build the skills of intermediate units and school personnel.

  The majority of PaTTAN's training programs are not designed to address the training needs of mental health workers; however several trainings focus on skills that aid educators in working with youth that have behavioral issues such as those that often accompany mental health issues.

  PaTTAN, along with the PA CASSP Training and Technical Assistance Institute, sponsored the 2006 School-Based Behavioral Health Conference in May 2006. This joint effort by PDE and DPW is designed to promote the academic achievement and well being of children through the development of a comprehensive, school-based, cross-community, behavioral health support system. Additionally, PaTTAN is hosting the 2006 National Autism Conference in July and August of 2006. This conference is bringing together nationally known experts and will provide comprehensive, evidence-based information to assist educators, providers, and families in developing effective educational and therapeutic programming for students with autism spectrum disorders.

- ***Center for Juvenile Justice Training and Research.*** The Juvenile Court Judges' Commission operates the Center for Juvenile Justice Training and Research, which provides a range of staff development opportunities designed to enhance the skills of professionals in the juvenile justice system. This state-sponsored training program offers training opportunities that include mental health related components as well as trainings that specifically focus on the mental health of youth that are in contact with the juvenile justice system. These trainings include psychiatric disorders associated with violence, post-traumatic stress disorder, various counseling related programs, and drug and alcohol dependencies.

Training of Children's Mental Health Workers. Despite these training programs, the need for additional training and improved coordination of existing training was frequently cited as a "gap" in the Commonwealth's child mental health system. To address this need, the 2006 Governor's Commission report on children's mental health recommends enhanced training to counties, especially on evidence-based practices and programs. The Children's Behavioral Health Task Force report discussed in Chapter III.A is also expected to identify the need for improved and better coordinated training as one of several key areas needing attention.

I. Culturally Appropriate Services

DPW officials and other stakeholders have identified an ongoing concern that behavioral health providers do not adequately provide relevant treatment services that address the cultural differences of their clients. Providers in Pennsylvania must not only consider the large population of differing ethnic communities, but must also address the cultural differences between the urban and rural cultures across the state.

The cultures of ethnic and racial minorities influence how patients communicate, display symptoms, and cope with problems, while the cultures of the providers influence diagnosis, treatment, and service delivery. As society becomes increasingly diverse, it is important that mental health providers embrace a culturally sensitive approach to providing services. This concept goes beyond having a clinician who speaks the same language, is of the same gender, race, or ethnic background as the client. Culturally competent agencies and organizations understand, respect, and respond to individual cultural needs in the clients they serve.

In 1998, OMHSAS established the Cultural Competency Advisory Committee to provide input on the complex cultural issues faced by the behavioral health service system. This committee defined cultural competence as:

> *A set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals, enabling them to work effectively in cross-cultural situations.*

The Cultural Competency Advisory Committee developed a set of clinical and rehabilitative standards for statewide use. These standards, published in 2004, are designed to ensure inclusion, access, and full participation of cultural and ethnic groups in the behavioral health care and substance abuse system of services. The standards focus on ethnic groups and culture and also address differences in age, gender, language, sexual orientation, religious beliefs, and physical abilities.

The CASSP Institute has developed a training manual, *A Cultural Competence Train-the-Trainers' Manual*, to address this need. The Institute offers training and technical assistance on how to provide culturally competent clinical services to children and families. CASSP has also reviewed all of its training materials to assure they reflect culturally competent principles.

Because many of those who provide mental health services received their training before the emphasis on cultural competence was incorporated in college curriculum, continuing training appears necessary to address this "gap." However, such training can take time away from service provision and some agencies may be reluctant to provide cultural competency training because of resource constraints and financial concerns.

VI. Although Few Act 147 Petitions Have Been Filed, Additional Guidance Is Needed to Inform Providers of Their Responsibilities Under the Act

As of January 2006, we could identify only three petitions,[1] two from Westmoreland County and one from Centre County, that have been filed by minors 14-17 years of age challenging their placement as provided for by Act 147.[2] Although it distributed preliminary comments in January 2005, as of May 2006, DPW had not issued final guidance regarding the implementation of Act 147 to counties or providers as to their responsibilities for advising minors 14-17 years old of their rights and the procedure to use when filing petitions in challenging their placement or treatment. A few counties have developed specific guidance on this matter, but most appear to be awaiting state guidance.

Statutory Provisions

Act 2004-147 amended the statute that enables certain minors to consent to medical, dental, and health services and authorizes parental consent for mental health treatment for certain minors. Under the provisions of this act, minors ages 14-17 can consent to both inpatient and outpatient mental health treatment. Prior to this, under the Mental Health Procedures Act, minors 14-17 could consent to inpatient treatment but the act was silent on outpatient treatment.[3] More importantly, Act 147 also authorizes parents to consent to inpatient mental health treatment, on the recommendation of a physician who has examined the minor, or outpatient services for children under age 18. Please see Exhibit 13 for the key provisions of the act as well as a comparison with Mental Health Procedures Act provisions.

Neither the parent nor the minor 14-17 may override the consent provided by the other party. Therefore, a process to object to the treatment process was included in the act for minors.[4] The act requires the director of the admitting facility to provide the minor aged 14-17 with an explanation of the nature of the mental health treatment in which he/she may be involved, together with a statement of his/her rights, including the right to object to the treatment by filing a petition with the court. The director is to provide a form for the minor to use to request

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[1] We identified the petitions based on our visits to counties, questionnaire responses from county MH personnel, telephone calls to selected county courts, and a telephone survey of all counties conducted by the Juvenile Law Center in late 2005.

[2] Another petition was filed in Allegheny County and involved a minor who had been placed by the court under the Juvenile Act. The petition was denied since the placement was not under the provisions of Act 147.

[3] DPW, however, issued a bulletin interpreting this provision to authorize a 14–to-17-year-old to consent to outpatient treatment since outpatient treatment is less restrictive than inpatient treatment.

[4] In addition to the process for the minor 14-17 to object to treatment, the act provides for a nonconsenting parent who has legal custody rights of a minor child to object to the consent given by the other parent to inpatient treatment by filing a petition with the court of common pleas.

Exhibit 13

Key Provisions of Act 2004-147

Amended the act that enables certain minors to consent to medical, dental, and health services and also authorized parental consent for mental health services for certain minors.

Consent by Minors 14 to 17 for Mental Health Services

Minors between the ages of 14 and 17 can consent to both outpatient and inpatient MH services. Prior to this, under the Mental Health Procedures Act (MHPA), these minors could consent to inpatient services. Consent to outpatient services was not clearly addressed.

Consent by Parents or Guardians for Mental Health Services for Minors

Parents or legal guardians can consent to both inpatient, on the recommendation of a physician who has examined the minor, and outpatient MH services for minors under age 18. Prior to this, under the MHPA, a parent could consent for minors under the age of 14 for inpatient MH services.

Non-consenting parent with custody rights of a minor child may object to consent given by the other parent for inpatient treatment by filing a petition with the court of common pleas.

The minor may not abrogate consent given by the parent and the parent may not abrogate consent given by the minor. The minor has authority to object to the parent's consent to inpatient treatment as discussed below. The parent may object to the minor's consent to inpatient treatment under provisions of the MHPA (a hearing within 72 hours by a judge or mental health officer who shall determine whether the voluntary treatment is in the best interest of the minor).

Duration of InpatientTtreatment

The minor who has provided consent to inpatient treatment may revoke that consent at any time. That revocation is effective unless the parent or legal guardian consents to continued treatment. Discharge will also occur when the attending physician finds that the minor is no longer in need of treatment.

Rights of Minors to Petition for Withdrawal or Modification of Inpatient Treatment

The director of the inpatient facility is required to inform the minor aged 14 to 17 of the treatment plan and the minor's right to object to the treatment by filing a petition with the court requesting modification of or withdrawal from the treatment.

A minor 14 to 17 who is confined on his parent's consent may object to the confinement by filing a petition in the court of common pleas requesting withdrawal from or modification of treatment. The court is to appoint counsel and schedule a hearing within 72 hours. To continue placement without the minor's consent, the court must find:

1. that the minor has a diagnosed mental disorder;
2. that the disorder is treatable;
3. that the disorder can be treated in the particular facility where the treatment is taking place; and
4. that the proposed inpatient treatment setting represents the least restrictive alternative that is medically necessary.

The act provides time frames for court determined treatment: after the initial review the court can order treatment up to twenty days; in a subsequent review the court can order treatment for up to sixty days; for additional reviews the procedure for the sixty-day period of treatment is repeated until the court determines to release the minor or the minor is discharged by the attending physician.

Release of Medical Records

When the parent or legal guardian has provided consent, the act authorizes the parent or legal guardian to release the minor's medical records to the minor's current mental health treatment provider. The minor's mental health records may be released to the primary care provider if in the judgment of the current mental health provider such would not be detrimental to the minor.

The parent or legal guardian consenting to treatment for a minor 14 to 17 has the right to information necessary for proving consent to the treatment.

Except as discussed above, the minor controls the release of his mental health treatment records to the extent allowed by law.

Source: LB&FC staff review of Act 2004-147 and the Mental Health Procedures Act, 50 P.S. §7101 et seq.

modification or withdrawal from treatment. If the minor aged 14-17 objects to the treatment consented to by the parent, the act requires the director of the facility in which the minor has been placed to file a signed petition with the court.

The court is to appoint counsel for the minor and schedule a hearing within 72 hours. To continue placement without the minor's consent, the court must find that:

- the minor has a diagnosed mental disorder;
- the disorder is treatable;
- the disorder can be treated in the particular facility where the treatment is taking place; and
- the proposed inpatient treatment setting represents the least restrictive alternative that is medically necessary.

The act provides time frames for court determined treatment and additional review.

January 2005 Department of Public Welfare Response

In January 2005, approximately three days before the effective date of Act 2004-147, DPW's Office of Mental Health and Substance Abuse Services (OMHSAS) Bureau of Children's Services issued a draft "issue and response" document regarding Act 147 and indicated that a formal agency bulletin would be subsequently issued. As of May 2006, no subsequent guidance on the implementation of this act has been issued by the Department.

The January 2005 document, see Appendix O, states that "Although Act 147 directly affects mental health providers and agencies, there are no provisions in the act that give any state agency the authority to promulgate regulations specific to the act." The document advises providers to consult with their professional organizations and legal representatives to determine how they should appropriately implement the act. The document also states that DPW will issue suggested draft language for the petition form referenced in the act if a minor objects to inpatient treatment.

Minimal and Varied County Actions

County actions to implement Act 147's requirements vary significantly, and some counties have not yet addressed this matter. In some cases, counties have developed guidance for their providers to use in implementing the act that includes a form petition for the provider to use if a minor seeks to withdraw from or seeks modification to treatment under the act. Berks County, for example, has issued a policy statement and petition form to its providers, and Westmoreland County has developed a protocol for these hearings. In another case, a provider has developed its own policies and form. Delaware County personnel have met with their president judge and established a system to respond to these petitions that parallels their mental health court. Several counties indicated in their response to a Juvenile Law Center (JLC) survey that they intend to use the same procedures for these petitions that they do for certain Mental Health Procedures Act hearings, e.g., holding the hearing at the facility rather than in the courtroom. There are, however, concerns about the act and the lack of formal guidance from the Department.[5]

For example, several counties' officials questioned the time frame for filing the petition (the act is silent), whether "facility" under the act includes residential treatment facilities, how to transport a minor who is not consenting to treatment, and who is financially responsible for the minor's counsel. Advocacy groups and providers have noted similar concerns. County respondents to our questionnaires also noted the need for training on the act, specifically how it relates to the Mental Health Procedures Act and the MH/MR Act of 1966. Under the MHPA, a 14- to 17-year-old may consent to treatment but then can withdraw the consent. The options available under that act are for the facility to discharge the individual or, if sufficient grounds exist, seek involuntary commitment. A county respondent questioned whether the facility must now notify the parent and give the parent the opportunity to consent to continued treatment under Act 147.

According to DPW counsel, the Department has not issued final formal guidance because Act 147 amended an act for which DPW does not have specific administrative responsibility. Therefore, DPW has been hesitant to issue guidance to the counties and providers regarding the petitions filed by minors under the act. Counsel indicated that DPW will issue guidelines for Act 147, but similar to that which was issued in January 2005; it will not issue a binding legal opinion.

Pursuant to the Public Welfare Code, 62 P. S. §§901—922 and 1001—1080, the Department of Public Welfare has supervisory authority over all state institutions, including children's institutions and state-licensed boarding homes for children. The Department is further authorized and empowered to adopt regulations establishing minimum standards for buildings, equipment, operation, care, programs, and services and for the issuance of licenses for these institutions.

Under this authority, the Department has promulgated regulations at 55 Pa. Code Chapter 3800 for the purpose of protecting the health, safety, and well-being of children receiving care in a child residential treatment facility. These regulations set out requirements for staffing, dispensing medication, facility safety, medical and dental care to be provided, treatment plans, and programs that are provided at the facility, among other matters. These regulations also specifically define the rights of the minor in treatment and require the facility to provide notice of rights and grievance procedures to the child and parent.

Many of the facilities providing children's mental health services are governed by these standards, and DPW could issue its guidance under this same

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[5] The complete results of the JLC survey are on their website at www.jlc.org

authority. DPW counsel also indicated that an amendment to Act 147 specifically authorizing DPW to issue regulatory guidance in this area could clarify DPW's authority to provide guidance on the requirements of the act to providers.

Disposition of Petitions

As noted above, we identified only three petitions that have been filed under the provisions of Act 147. In the first case, the minor involved was from another county. This minor petitioned to be released from treatment, but was ordered to continue treatment for 20 days, as provided by the act, in a residential treatment facility. A subsequent hearing was held and her stay was continued for an additional 60 days. Shortly after that hearing, a facility closer to her home was identified, and she dropped her objections to treatment after she was transferred back to her home county.

In the second case, another out of county minor objected to his placement in an adolescent inpatient treatment unit by his parents. He was committed by the court for the initial 20 days and was discharged prior to the expiration of that time period. In the third case, the minor voluntarily placed himself in a facility, but when he wanted to leave, his parents consented to his continued treatment under the provisions of Act 147. He filed a petition, and the court ordered his continued treatment. He was discharged to outpatient treatment seven days later.

According to many of the county personnel, providers and advocates we spoke to, although they have received queries about the consent and petition provisions of the act, the vast majority of the issues regarding treatment are worked out between the participants before a formal petition is filed. We have also been told that certain facilities will not accept a minor 14-17 years old without the minor's consent.

Due to the small number of petitions that have been filed with the court under the act, the impact on the courts has been minimal, although concern over possible future problems remains.

Effectiveness of the Act

Approximately 20 percent of the MH/MR and OCYF respondents to our questionnaires indicated that they noticed significant changes to the mental health system for children and youth as a result of the requirements of Act 147 related to consent to treatment, ability to object to treatment, and the release of records. The majority, however, did not indicate they noticed significant changes. Many of the county mental health staff commented that, although they had not had any petitions filed, they had received questions about the process. According to these staff, the provisions in the act that authorize consent by the parent of a 14- to 17-year-old have provided a means for the parent to negotiate with the child to voluntarily consent to treatment. None of the counties had any data on how frequently this may occur, but viewed it as helpful in getting necessary treatment for these children. Several of the advocates we met with had the same experience with their clients.

Several other county staff and advocates expressed their concern over the standards for placing a 14- to 17-year-old in treatment without his or her consent. Unlike the more stringent standards of the MHPA, consent to inpatient treatment by a parent for a 14- to 17-year-old under Act 147 requires only the recommendation of a physician who has examined the child. No showing of harm to self or others need be made, and the physician need not have any special psychiatric training. These staff and advocates were concerned that the provisions of the act may be used to address issues with an unruly child rather than one who has mental health issues; however, no specific examples of this occurring were provided to us.

VII. Status of Implementation of the 2004 Interdepartmental Task Force Report on Autism and Related Initiatives

In December 2004, the Autism Task Force released its findings concerning the problem that the Commonwealth faces in providing care to the growing population of individuals diagnosed with Autism Spectrum Disorder (ASD). The Task Force noted that, during the 15-year period preceding the study, the number of persons in Pennsylvania diagnosed with ASD grew by over 2,000 percent. According to the report, over 40 children per 10,000 are diagnosed with ASD each year. This places a growing strain on the state and local agencies responsible for providing care for this population.

The Task Force, comprised of over 250 family members of people living with autism, service providers, educators, administrators, and researchers, set out to identify the existing problems with autism service delivery and to develop a plan for a new system for individuals living with autism and their families. The Task Force's work culminated in the identification of eight specific problems with the current system and proposed recommendations to those problems. Additionally, five major solutions were identified that would improve the organization, financing, and delivery of services to people living with autism in Pennsylvania. The Departments of Public Welfare and Education have assigned specific staff, established work groups, and developed implementation strategies related to the report's recommendations that were beginning to become operational as of early 2006, in part aided with $3.0 million in specific funding for such endeavors through a FY 2005-06 state General Fund appropriation.

Task Force Problems Identified and Solutions Presented in the Report

Structure of MH/MR Programs

The mental health/mental retardation system is not structured to adequately meet the needs of people living with autism and other chronic neurodevelopmental disorders. Service depends greatly on age and the IQ of the individual living with autism, which is also a determining factor in whether the mental health or the mental retardation system provides those services. The mental health system's reliance on short-term treatment has also been a source of concern. Service providers receive constant pressure to discharge children from care or to reduce the volume of services provided. This pressure is demonstrated by requirements for re-evaluations every four months for service reauthorization.[1]

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[1] To address this issue, DPW issued an MA Bulletin, which became effective on August 1, 2005, that permits BHR services to be authorized for up to twelve months for children and adolescents with behavioral health needs compounded by developmental disorders such as autism or other pervasive disorders if the nature of the disorder is such that the medical necessity for the level of care is expected to continue throughout the authorization period.

The Task Force suggested that regulations to allow annual reauthorization of services for children with chronic conditions and disorders would alleviate this problem. Service providers should also not have to rely on the IQ requirements to allow all individuals with autism to be treated through the same system. Services for those living with autism should be considered an entitlement throughout an individual's lifetime. Additionally, to create a comprehensive system that is specifically designed to meet the needs of the autism population, there need to be advances in regulating and licensing providers, developing and making available appropriate services, and establishing appropriate protocols for receiving those services. The Task Force suggests that Pennsylvania should create an Office of Disabilities in the Department of Public Welfare (DPW) with the mandate of implementing these goals.

Work Force

Pennsylvania is lacking in qualified, trained professionals to evaluate, treat, educate, and provide other services to people living with autism. This results in delayed diagnosis and inappropriate care for persons with autism. Suggested solutions are reimbursement for training, creating more stringent licensing and regulatory requirements, reimbursing at higher rates for quality services, recruiting nationally for qualified providers, and specifying the services for which people with autism are eligible. Also, training should include all professionals who have the potential to come into contact with children living with autism and should be able to recognize core symptoms of the disorder in order to make appropriate referrals. Long-term solutions include improving the state infrastructure, incentives for developing professionals, loan forgiveness programs for individuals specializing in the field of autism, and improved training and licensing programs at local colleges and universities.

Community-Based Services

A lack of community-based services exists for adults with autism. Once individuals living with autism turn 21, there are few services available to them, and they lose any previous entitlement to service. The Task Force concluded that services for adults with autism should be an entitlement and should continue throughout the individual's lifespan. Those services should also be broadened to acknowledge that autism is a spectrum disorder with the needs and abilities varying greatly per individual. Life and social skills training and support can allow many adults living with autism to live independently within their community. Many individuals can benefit from a variety of learning tools such as vocational skills training, job coaching, and post-secondary education if provided the necessary supports. One important mechanism to assist in addressing this problem would be implementing a Medicaid waiver. Waivers of state Medicaid plans offer the flexibility to provide needed services that are outside the traditional scope of care.

Coordination Across Multiple Systems

Coordination needs to be improved within and across the multiple systems that provide care for people living with autism. The fragmentation of autism services results in a lack of coordination that leads to gaps and overlaps of services. The numerous agencies involved in providing care often results in multiple assessments by differing specialists, which can lead to differing treatments. Children with autism can receive services from both the education system and the Medical Assistance system, which results in two differing sets of interventions with unique goals. The two systems have fundamentally different missions involved in the services they provide, which results in further complications. These fragmentation issues result in funds not being used in the most efficient manner.

The Autism Task Force stressed the need for more coordination and cooperation between groups that provide services to persons living with autism. The need for one coherent service plan requires that funding streams and services be coordinated. The Task Force suggested the development of a Bureau or Division of Autism Spectrum and Related Disorders within an Office of Disabilities in DPW to address this issue. This Bureau or Division could coordinate funding across agencies and create incentives to ensure that different care plans are tied together into a single, coherent plan.

Incentives for Quality of Care

The lack of incentives provided for delivering quality care was the fifth identified deficiency. There are currently no criteria at either the state or local levels regarding what constitutes an appropriate care package for people living with autism. There is also an absence of standardized methods for measuring processes and outcomes within the system. New treatment plans can result in lengthy negotiations over the appropriate level, intensity and duration of care and related reimbursement. Additionally, these issues result in conflict over necessary staff training and culminate with staff pay scales that are not competitive with alternative employment options. A lack in employer-provided healthcare and other benefits also contributes to high staff turnover rates and staffing shortages.

The Task Force recommended developing appropriate standards of care and working with providers to improve their abilities to meet those standards. Other states, such as California, New York, Indiana, and Washington, have implemented such programs that could be used as models. Performance-based contracting, with the provider's contract based on quality of care, outcomes, and client satisfaction, should be established, with the aforementioned Office of Disabilities being responsible for the development of appropriate quality and outcome measures throughout the Commonwealth. An on-going review entity should be created to provide guidelines and oversee implementation of quality standards and performance-based contracting. Efforts should be made to reduce and streamline the amount of paperwork the current system produces and new requirements should be consistent across the Commonwealth.

Pay scales should also be increased to a level competitive with alternative employment and reflecting the education required for staff in these positions. Training and attendance at evaluations should be a billable expense that would reduce the overhead for providers, allowing for higher salaries without significant increases in the hourly reimbursement rate from the state. Methods to address the creation and maintenance of employee satisfaction and retention of employees must be developed to address the tremendous amount of time, skill, and resources lost to high turnover rates.

Consistent Statewide Policies and Programs

No cohesive set of policies and planning exist to provide consistent care and education to people living with autism across the Commonwealth. The variation across the 501 school districts, 29 intermediate units, and 67 counties results in different levels, quality, and administration of services. The Task Force recommends the development of a core set of required services, supports, and regulations that allow room for local flexibility when needed. Guidelines should be developed for individuals throughout their lifetime regarding screening, assessment, diagnosis, treatment, and related support services. The Pennsylvania Department of Education should take a proactive role in developing and implementing a consistent educational standard of practice for children living with autism that holds every school district accountable to provide the same developed standard of practice. Additionally, regional centers should be organized to serve as sources of the most current information in the nature and treatment of autism and could be used as a resource for providers to coordinate consistent practices across regions of the Commonwealth.

Outreach and Education

The system is incapable of adequately addressing differences in individuals living with autism. Families living with autism vary widely, reflecting that persons of all ethnic and socio-economic groups are affected. The current system places the burden on families to seek information on autism, learn what services are available, apply for those services, and coordinate those services from different sources. Families are left with few resources to assist them in managing the challenge of autism. This is particularly a problem for those that do not possess the necessary financial resources, command of the English language, or knowledge of the function of state and local bureaucracies or who live in areas where services are not readily available.

Services for individuals living with autism must reflect, respect, and accommodate the diversity and multicultural composition of the Commonwealth, while still providing a single point of entry into the service system. That entry point should provide materials in different languages, easy access to professional advocates who can work with families, methods to eliminate disparities in access to services, training that makes parents aware of their rights and responsibilities, culturally sensitive and competent providers that can work well with families from a variety of different backgrounds, and improved access to services regardless of where families live. More research is needed regarding the effect and implications of geographical, socio-economical, educational, and cultural differences, with respect to disparities in access to services and care for individuals living with autism.

Special Education

The current education system does not meet the needs of people living with autism. The Office of Special Education within the Department of Education (PDE) serves more persons living with autism in the Commonwealth than any other agency. Since 1990, the number of persons with ASD who qualify for special education services has grown by over 1,000 percent. The education system has struggled to develop coherent and meaningful policies and services for this population. Individual school districts have considerable autonomy in defining autism-related services that ultimately results in great variation across the Commonwealth. This leaves families with an inconsistency of available options and requires them to push to obtain sufficient and appropriate services. Many schools do not offer programs that address the core deficits of autism, namely social and language training. Compounding these problems is the lack of coordination between the education and Medicaid systems. Both require specific care plans that are designed to address essentially the same goals and objectives. The result is services that are fragmented, less effective and efficient, which results in additional costs.

The Autism Task Force Report addresses this problem in three parts that address ways to increase service capacity in the education system, the inconsistency in educational services across Pennsylvania and the coordination of services provided in the educational and behavioral health systems:

- Solutions designed to address autism services first stress the need for more trained professionals to educate children living with autism. Programs promoting in-service training for current regular and special educators, incentives such as loan forgiveness for pre-service training in autism, and efforts to increase the capacity of local colleges and universities to train people in autism education are greatly needed.
- Additionally, creating cohesive, statewide rules for administering a menu of appropriate services based upon the best available practices should be given a high priority. Rules should dictate that inclusion be the first

option considered, social skills and pragmatic language deficits always be addressed, consistent policies regarding services beyond the regular school day and year be implemented, and vocational training be stressed.

- To facilitate the coordination of education and behavioral health services, the report recommends that an appropriate infrastructure be created. A Bureau or Division of Autism Spectrum and Related Disorders, housed within an Office of Disabilities, could provide the essential means to facilitate greater coordination in the Department of Education. Both sources need to coordinate in order to develop a single, coherent treatment plan for each child.

Overall Task Force Report Solutions

The five major solutions that the Autism Task Force identified to address these problems and to improve the organization, financing, and delivery of services to people living with autism in Pennsylvania are as follows:

- Create an Office of Disability within the Department of Public Welfare with a Bureau or Division of Autism Spectrum and Related Disorders.
- Create a consumer-led information and advocacy organization.
- Develop an Autism-specific Medicaid waiver.
- Situate regional autism centers across the state.
- Develop creative mechanisms for blending and braiding funding between education and Medicaid to ensure coordinated, collaborative care across systems.

Autism Task Force Update—April 2006

Following the release of the Autism Task Force report, DPW appointed a Director of Autism Affairs to facilitate the implementation of those recommendations within DPW and across other impacted Commonwealth agencies. As of May 2006, a primary recommendation to develop creative mechanisms for blending and braiding funding between education and behavioral health was being explored through six pilot proposals which seek to find innovative ways to combine services from both systems. An RFP was issued in the spring of 2006 and 44 proposals were submitted for review. Six of those have been awarded one-year grants of $175,000.

Other initiatives launched in Phase 1 include projects to train diagnosticians—one at the University of Pittsburgh, and the other at the Children's Hospital of Pennsylvania. A census of persons in the Commonwealth with ASD is expected to be completed within six months. Autism Affairs staff have identified training needs and conducted training sessions across a variety of organizations, including providers of BHR services, county MH/MR staff, Youth Development Centers (New Castle), Department of Health (Special Kids Network), and state hospitals

(Warren). Objectives delineated for Phase 1 include focusing on the need for statewide training of adult service providers and establishing a model of service delivery for addressing the unique needs of children and adolescents with ASD residing in rural areas of the Commonwealth. The focus of these objectives will work toward the need for increased training and capacity building within the system.

In the coming year, Autism Affairs will also be focusing on several additional areas. These include the development of a standard of assessment for adults with ASD, the identification and development of a model of transition services for individuals entering adulthood and leaving the education system and the challenges posed to and by the juvenile justice and criminal justice systems where an increasing number of persons with ASD, some undiagnosed, are ending up. Several of these issues are of mutual concern to a number of neighboring states with whom Autism Affairs hopes to collaborate.

To further address the need for increased training and capacity building, the Autism Affairs Director and DPW singled out five primary objectives to be addressed in 2006:

- **Establish a statewide diagnostic standard and train physicians to diagnose autism**. Current statewide capacity finds families waiting from 8 to 18 months to see a physician who is qualified to make a diagnosis of autism. This extensive waiting period severely hampers efforts at early intervention and action. Training will be focused on physicians, nurse practitioners, and clinicians from across the Commonwealth.

- **Collaboration with Department of Education on Standards and training.** Currently, there is no uniform autism specific assessment, intervention, or training standard within the Commonwealth. In addition, there is a tremendous need to build capacity among clinicians and educators working directly with individuals with autism. This has resulted in wide variation in the quality of intervention across the state. To address this, a collaborative effort with PDE has been undertaken to identify standards across these domains and to partner in training and capacity building as much as possible. DPW has awarded 200 scholarships for BHRS direct service staff to attend the National Autism Conference in August, sponsored by PDE.

- **Develop a model of service delivery to meet the unique needs of individuals with autism living in rural areas of the state.** This objective is being initiated in response to the specific needs associated with rural areas that differ in large part from other areas of the Commonwealth.

  In May 2006, DPW released an RFP through the Tuscarora Intermediate Unit seeking providers interested in developing and piloting effective models of care for children and adolescents diagnosed with ASD, focusing specifically on the challenges of providing services to individuals with autism in rural areas. The grant award for this RFP is $200,000.

- **Design comprehensive and standardized training modules and protocols that may be utilized by providers statewide who are currently providing or are seeking to provide services to adults with autism across home, work, and community settings.** The autism report indicates that currently, few providers understand the needs of the adult population with ASD.

  As of early May 2006, DPW was drafting an RFP to provide up to $100,000 in funding over the course of one year to develop modular, electronic (CD or internet accessible format) manualized training materials that will be used by service providers serving adults with ASD.

- **Establish statewide and regional informational resources for families of individuals with autism.** The amount of knowledge currently necessary for families to understand how to navigate a fragmented and complex service delivery system is inadequate. The goal in developing such information materials is to provide families with a single point in which they can access information about services and supports that are available from the state.

VIII. Appendices

APPENDIX A

Mental Health Treatment - Consent to Treatment, Release of Medical Records

(Act of Nov. 23, 2004, P.L. 1149, No. 147 Cl. 35, Session of 2004, No. 2004-147

S.B. No. 137

AN ACT Amending the act of February 13, 1970 (P.L.19, No.10), entitled "An act enabling certain minors to consent to medical, dental and health services, declaring consent unnecessary under certain circumstances," further providing for consent to treatment; providing for release of medical records; and requiring a report by the Legislative Budget and Finance Committee.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of February 13, 1970 (P.L.19, No.10), entitled "An act enabling certain minors to consent to medical, dental and health services, declaring consent unnecessary under certain circumstances," is amended by adding sections to read:

Section 1.1. Mental Health Treatment.[1]

(a) The following shall apply to consent for outpatient treatment:

(1) Any minor who is fourteen years of age or older may consent on his or her own behalf to outpatient mental health examination and treatment, and the minor's parent or legal guardian's consent shall not be necessary.

(2) A parent or legal guardian of a minor less than eighteen years of age may consent to voluntary outpatient mental health examination or treatment on behalf of the minor, and the minor's consent shall not be necessary.

(3) A minor may not abrogate consent provided by a parent or legal guardian on the minor's behalf, nor may a parent or legal guardian abrogate consent given by the minor on his or her own behalf.

(b) The following shall apply to consent for inpatient treatment:

(1) A minor's parent or legal guardian may consent to voluntary inpatient treatment pursuant to Article II of the act of July 9, 1976 (P.L.817, No.143),[2] known as the "Mental Health Procedures Act," on behalf of a minor less than eighteen years of age on the recommendation of a physician who has examined the minor. The minor's consent shall not be necessary.

(2) Nothing in this section shall be construed as restricting or altering a minor's existing rights, including, but not limited to, those enumerated under the "Mental Health Procedures Act"[3] to consent to voluntary inpatient mental health treatment on his or her own behalf at fourteen years of age or older.

(3) Nothing in this section shall be construed as restricting or altering a parent or legal guardian's existing rights to object to a minor's voluntary treatment provided pursuant to the minor's consent on his or her own behalf.

(4) A minor may not abrogate consent provided by a parent or legal guardian on the minor's behalf, nor may a parent or legal guardian abrogate consent given by the minor on his or her own behalf.

(5) A parent or legal guardian who has provided consent to inpatient treatment under paragraph (1) may revoke that consent, which revocation shall be effective unless the minor who is fourteen to eighteen years of age has provided consent for continued inpatient treatment.

(6) A minor who is fourteen to eighteen years of age who has provided consent to inpatient treatment may revoke that consent, which revocation shall be effective unless the parent or legal guardian to the minor has provided for continued treatment under paragraph (1).

(7) At the time of admission, the director of the admitting facility or his designee shall provide the minor with an explanation of the nature of the mental health treatment in which he may be involved together with a statement of his rights, including the right to object to treatment by filing a petition with the court. If the minor wishes to exercise this right, the director of the facility or his designee shall provide a form for the minor to provide notice of the request for modification or withdrawal from treatment. The director of the facility or his designee shall file the signed petition with the court.

(8) Any minor fourteen years of age or older and under eighteen years of age who has been confined for inpatient treatment on the consent of a parent or legal guardian and who objects to continued inpatient treatment may file a petition in the court of common pleas requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to be held within seventy-two hours following the filing of the petition, unless continued upon the request of the attorney for the minor, by a judge or mental health review officer who shall determine whether or not the voluntary mental health treatment is in the best interest of the minor. For inpatient treatment to continue against the minor's wishes, the court must find all of the following by clear and convincing evidence:

(i) that the minor has a diagnosed mental disorder;

(ii) that the disorder is treatable;

(iii) that the disorder can be treated in the particular facility where the treatment is taking place; and

(iv) that the proposed inpatient treatment setting represents the least restrictive alternative that is medically appropriate.

(9) A minor ordered to undergo treatment due to a determination under paragraph (8) shall remain and receive inpatient treatment at the treatment setting designated by the court for a period of up to twenty days. The minor shall be discharged whenever the attending physician determines that the minor no longer is in need of treatment, consent to treatment has been revoked under paragraph (5) or at the end of the time period of the order, whichever occurs first. If the attending physician determines continued inpatient treatment will be necessary at the end of the time period of the order and the minor does not consent to continued inpatient treatment prior to the end of the time period of the order, the court shall conduct a review hearing in accordance with this subsection to determine whether to:

(i) release the minor; or

(ii) make a subsequent order for inpatient mental health treatment for a period not to exceed sixty days subject to discharge of the minor whenever the attending physician determines that the minor no longer is in need of treatment, or if consent has been revoked under paragraph (5).

(10) The procedure for a sixty-day period of treatment under paragraph (9)(ii) shall be repeated until the court determines to release the minor or the minor is discharged in accordance with paragraph (9).

(11) Nothing in this subsection shall prevent a nonconsenting parent who has legal custody rights of a minor child to object to the consent given by the other parent to inpatient treatment under paragraph (1) by filing a petition in a court of common pleas in the county where the child resides. The court shall hold a hearing on the objection within seventy-two hours of the filing of the petition.

(c) Nothing in subsections (a) and (b) is intended to restrict the rights of a minor who satisfies the conditions of section 1.

(d) As used in this section, the following words and phrases shall have the meanings given to them in this subsection: "Court of common pleas" means the court of common pleas in the county where the subject of the proceeding is being treated. "Facility" means any mental health establishment, hospital, clinic, institution, center, day-care center, base service unit, community mental health center, or part thereof, that provides for the diagnosis, treatment, care or rehabilitation of mentally ill persons. "Inpatient treatment" means all mental health treatment that requires full-time or part-time residence in a facility that provides mental health treatment. "Mental health treatment" means a course of treatment, including evaluation, diagnosis, therapy and rehabilitation, designed and administered to alleviate an individual's pain and distress and to maximize the probability of recovery from mental illness. The term also includes care and other services which supplement treatment and aid or promote recovery.

Section 1.2. Release of Medical Records.[4]

(a) When a parent or legal guardian has consented to treatment of a minor fourteen years of age or older under section 1.1(a)(2) or (b)(1), the following shall apply to release of the minor's medical records and information:

(1) The parent or legal guardian may consent to release of the minor's medical records and information, including records of prior mental health treatment for which the parent or legal guardian had provided consent, to the minor's current mental health treatment provider.

(2) If deemed pertinent by the minor's current mental health treatment provider, the release of information under this subsection may include a minor's mental health records and information from prior mental health treatment for which the minor had provided consent to treatment.

(3) The parent or legal guardian may consent to the release of the minor's mental health records and information to the primary care provider if, in the judgment of the minor's current mental health treatment provider, such release would not be detrimental to the minor.

(b) Release of mental health records and information under subsection (a) shall be limited to release directly from one provider of mental health treatment to another or from the provider of mental health treatment to the primary care provider.

(c) The parent or legal guardian who is providing consent to mental health treatment of a minor fourteen years of age or older under section 1.1(a)(2) or (b)(1) shall have the right to information necessary for providing consent to the minor's mental health treatment, including symptoms and conditions to be treated, medications and other treatments to be provided, risks and benefits and expected results.

(d) Except to the extent set forth in subsection (a), (b) or (c), the minor shall control the release of the minor's mental health treatment records and information to the extent allowed by law. When a minor has provided consent to outpatient mental health treatment under section 1.1(a)(1), subject to subsection (a)(2), the minor shall control the records of treatment to the same extent as the minor would control the records of inpatient care or involuntary outpatient care under the act of July 9, 1976 (P.L.817, No.143), known as the "Mental Health Procedures Act," and its regulations.

(e) Consent to release of mental health records for all purposes and in all circumstances other than those provided for in this section shall be subject to the provisions of the "Mental Health Procedures Act" and other applicable Federal and State statutes and regulations.

Section 2. No later than 12 months from the effective date of this act, the Legislative Budget and Finance Committee shall prepare a report on the mental health system for children and youth in this Commonwealth. The report shall evaluate the continuum of mental health services for children and their families and include a review of the availability of community-based outpatient and inpatient mental health services across this Commonwealth; statistical information on the number of children needing mental health services; a survey of the number of petitions filed under section 1.1(b)(7) and (8) of the act, including an assessment of those petitions resulting in treatment or continued treatment and the ordered treatment period; the timeliness and extent of services; costs for various types of mental health services for children and youth; the extent to which public and private health insurance, including medical assistance, provides coverage for different mental health treatment and services; gaps in mental health services for children and youth; and the impact and effectiveness of this act in respect to providing mental health treatment for children and youth. The Legislative Budget and Finance Committee shall report its findings and recommendations to the Judiciary Committee and the Public Health and Welfare Committee of the Senate and to the Judiciary Committee and the Health and Human Services Committee of the House of Representatives.

Section 3. This act shall take effect in 60 days.

APPROVED--The 23rd day of November, A. D. 2004.

EDWARD G. RENDELL

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[1] 35 P.S. §10101.1

[2] 50 P.S. §7101 et seq.

[3] 50 P.S. §7201 et seq.

[4] 35 P.S. §10101.2

APPENDIX B

Gaskin Agreement

A settlement agreement in Gaskin v. PA was approved by the Eastern District Court of Pennsylvania in September 2005. The lawsuit, originally filed in 1994, alleges that students with disabilities have been denied their federal statutory right to a free appropriate public education in regular classrooms with necessary supplemental aids and services. In particular, the plaintiffs allege that Pennsylvania Department of Education (PDE) has systematically failed to enforce the provisions in federal law requiring local school districts to offer a full continuum of support services allowing disabled children to be educated in regular classrooms. The class action suit is comprised of approximately 255,264 members. This total reflects the number of school-aged children, i.e., between the ages of 3 and 21, who have an IEP.

The settlement agreement requires the following:

- Creation of an advisory panel on least restrictive environmental (LRE) practices to provide input to the Director of PDE's Bureau of Special Education on technical, programmatic, and operational issues affecting the inclusion of students with disabilities in the regular education classroom.
- Modification of the IEP format and written guidance to all school districts.
- LRE compliance monitoring to ensure that districts comply with LRE provisions of IDEA and other federal and state laws protecting the rights of children with disabilities. The level of LRE monitoring depends on the LRE index score of the district.
- Complaint resolution to include investigation of all complaints. As part of the process, the PDE must use its best efforts to interview the students or the student's parents or guardians, and a reasonable number of witnesses.
- Synchronization of school district special education planning cycle with compliance monitoring cycle.
- Provision of on-site training, technical assistance, and professional development to school districts for the purpose of building local capacity in providing individualized supplementary aids and services enabling students to be educated in regular education classrooms.
- Agreement that PDE will provide a letter of support if plaintiffs seek certain grants related to the inclusion of students in the regulation education classrooms.

The term of the settlement agreement is five years. Last fall, members were appointed to the Bureau Director's Advisory Panel on Least Restrictive Environment. The panel has 15 members including 9 parents. The panel met in December 2005 and January 2006 to develop operating procedures. The meeting schedule will be posted on PDE's website and the meetings are open to the public.

Recently, school districts involved in the on-site LRE monitoring were identified and notified. PDE staff report that the Department began monitoring in the spring of 2006. PDE expects to complete on-site monitoring by the end of the school year.

Source: LB&FC staff review of Gaskin settlement agreement and PDE announcements.

APPENDIX C

Description of Arizona's Child and Family Team Approach

The Child and Family Team (CFT) approach used in Arizona was cited as a promising care management approach in the Health Care Reform Tracking Project study completed in 2005.[1] The approach is the result of a 2001 settlement agreement in which the Arizona Department of Health Services agreed to substantially improve the system for delivery of behavioral health services to the eligible children in accordance in part with twelve principles as delineated in the settlement agreement. These are:

Collaboration With the Child and Family: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

Functional Outcomes: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

Collaboration With Others: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client-centered teams plan and deliver services. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan, and (d) makes adjustments in the plan if it is not succeeding.

Accessible Services: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Case management is provided as needed. Behavioral health service plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

Best Practice: Behavioral health services are provided by competent individuals who are adequately trained and supervised. Behavioral health services are delivered in accordance with guidelines adopted by a DHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances; substance abuse problems; the specialized behavioral health needs of children who are developmentally disabled; maladaptive sexual behavior, including abusive conduct and risky behavior; and the need for stability and the need to promote permanency in class members' lives, especially class members in foster care. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.

Most Appropriate Setting: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

Timeliness: Children identified as needing behavioral health services are assessed and served promptly.

Services Tailored to the Child and Family: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

Stability: Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

Appendix C (Continued)

Respect for the Child and Family's Unique Cultural Heritage: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

Independence: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

Connection to Natural Supports: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

The department also agreed to develop and implement a statewide training program, add respite care to the list of covered services, devise and implement a means of allowing Regional Behavioral Health Authorities to contract with certified Masters level behavioral health professionals, expand Title XIX services, designate $600,000 for use as flex funds, develop practice guidelines for monitoring of medications, initiate a pilot project, develop annual action plans, change the quality management and improvement system, and involve plaintiffs' counsel and other stakeholders.

At the time of the study, the program focused on children and families with the most complex needs, such as children in out-of-home placements, multi-system involved families or children whose service plans have been unsuccessful. The intent is to extend the CFT process to every child enrolled in the mental health system in 2007. The CFT includes, at a minimum, the child and his/her family, any foster parents, a behavioral health representative, and any individuals important in the child's life and who are identified and asked to participate by the child and family, e.g., teachers, coaches. The team may have a Family Support Partner to help build the family voice within the team. Each team has a Clinical Liaison who has met credentialing and privileging standards and is responsible for supporting the family, facilitating the assessment process, coordinating with the child's health care provider, providing clinical expertise and advising the team on services, supports, and providers of potential benefit to the team. Caseload does not exceed 20 children per case manager.

All decisions of the CFT must be approved by the parent or guardian and, when appropriate, the child. The process does not end until the child is disenrolled from services or transitioned to the adult system. Before discharge, a crisis plan is developed that outlines the specific steps to reconvene the team and re-establish services and supports, if needed. Reportedly, this process has resulted in more community supports being involved in the behavioral health system, service plans expanded in scope to include more informal community resources, and a more congruent service planning process across the various child serving systems due to the unified service planning process. Challenges noted include the difficulty in changing work approaches, competition for direct care staff and the need for fiscal resources for training, coaching, and other quality assurance and quality improvement mechanisms.

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[1] The Health Care Reform Tracking Project (HCRTP) was co-funded by the National Institute on Disability and Rehabilitation Research in the U.S. Department of Education and the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. Supplemental funding was provided by the Administration for Children and Families of the U.S. Department of Health and Human Services, the David and Lucile-Packard Foundation, and the Center for Health Care Strategies, Inc. Since 1995, it has tracked public sector managed care systems and their impact on children with behavioral health problems and their families. The HCRTP was conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, DC, and the National Technical Assistance Center for Children's Mental Health at Georgetown University.

Source: Developed by LB&FC staff based on review of the JK v. Catherine R. Eden settlement agreement, No. CIV91-26 TUC JMR (2001), the Health Care Reform Tracking Project's 2005 study on Promising Care Management Approaches, and Arizona Department of Health Services protocols.

APPENDIX D

Other DPW 2006 Children's Mental Health Initiatives

Screening and Assessment Efforts in Child Care for Mental Health

To bring mental health consultation services to early learning programs, the Office of Child Development reports having initiated two projects.

Heinz Infant-Toddler Mental Health Consultation Project

Funded by the Heinz Endowments, the Office of Child Development has created staff positions in western Pennsylvania to provide direct consultation services to early learning programs and to work on developing a systemic approach to infant-toddler services more generally. Infant-Toddler Mental Health Specialists primarily are charged with responding to referrals from early learning programs for children who exhibit behavioral challenges. The specialists can provide intervention via phone or visits to the site and may address the expressed needs by training and modeling behaviors for staff, suggesting quality improvement procedures for the program, working directly with the child and his/her family, or providing referrals for additional supports (such as to Early Intervention or Mental Health providers) if applicable. The Infant-Toddler Coordinators primarily work on creating collaboration across various programs that serve infants, toddlers, and their families such as Early Intervention, Mental Health, family support, child care, Early Head start, etc.

The project started in January 2006, has been funded for two years, and will provide "lessons learned" for how to implement mental health consultation services statewide.

Project in Discussion: Mental Health Consultation—Office of Child Development and Office of Mental Health and Substance Abuse Services Collaboration

At the same time as the privately-funded mental health consultation project is occurring, the Office of Child Development (OCD) recognized the necessity of developing a mechanism within state government to provide the services. Thus, in May 2006, OCD and the Office of Mental Health and Substance Abuse Services (OMHSAS) convened a work group to identify how mental health consultation services could be provided to early learning programs. OCD and OMHSAS staff are in the process of identifying service provisions models and funding requirements to initiate a mental health consultation program for early learning programs. The timeline is to have a budget and implementation plan specified for the project by August 2006. Specific topics to be addressed include: identifying the criteria under children and programs could be service, identifying the types of providers who would be eligible to serve the population, developing frameworks for reimbursement, etc.

Source: DPW's Office of Child Development.

APPENDIX E

Restrictive Procedures

At times, residential treatment facility staff may use restraints or seclusion to ensure the safety of the residents and staff. This practice has come under scrutiny recently due to injuries and deaths suffered by children in such facilities. The Pennsylvania Protection & Advocacy, Inc., (PP&A) in January 2006, sent a letter to the Secretary of the Department of Public Welfare urging the Department to implement practices that may help to eliminate the unnecessary use of restraints.[1] Included in this letter was a report of incidences requiring off-campus medical treatment for children injured due to the use of restraints. This report shows that in 2005, 14 children required medical treatment; 13 of these cases were reported from the western region and 1 from the central region, which involved the death of a child.[2]

Deaths and injuries resulting from the use of restraints have also recently received media attention. For example, several Lancaster area newspapers reported on the deaths of two children that occurred in early 2006 after incidents in which they were restrained.[3] Additionally, in October 1998, the *Hartford Courant*, a newspaper in Connecticut, published a series of articles on this subject; the research was prompted by the death of an 11-year old boy in a Connecticut psychiatric hospital. As part of this investigation, the team reviewed numerous policy reports and academic studies, traveled to ten states, surveyed federal databases and electronic news archives, and spoke to hundreds of regulators, industry officials, analysts, workers, and patients. The reporting team also conducted a 50-state survey to document deaths that occurred during or shortly after restraint or seclusion. The team concentrated on the period from 1988 to 1998. As a result of this effort, the team compiled a database of 142 patient deaths in psychiatric hospitals, psychiatric wards of general hospitals, group homes and residential facilities for troubled youths, and mental retardation centers and group homes.

Current Regulations

DPW has promulgated regulations relating to the use of restraints in residential and day treatment programs. The regulations (55 Pa. Code §3800.201 - §3800.213) define a restrictive procedure as including chemical restraint, exclusion, manual restraint, mechanical restraint and seclusion. A restrictive procedure may not be used in a punitive manner, for the convenience of staff or as a program substitution; a restrictive procedure may be used only to prevent a child from injuring himself or others. Use of certain restrictive procedures, such as seclusion, aversive conditioning, and mechanical restraints, is prohibited. Use of chemical restraints, pressure points, exclusion, and manual restraints is permitted only under certain conditions.

The regulations require that, for each incident in which use of a restrictive procedure is considered, every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures. Further, a restrictive procedure may not be used unless less intrusive techniques and resources appropriate to the behavior have been tried but have failed and must be discontinued when the child demonstrates that he or she has regained self-control. Only staff trained in the use of restrictive procedures may use such a technique, and a record of each use of a restrictive procedure shall be kept.

Recent "Special Transmittal" and DPW Actions

To further explain the regulations and its new goal of a "restraints free" environment, DPW issued a "Special Transmittal"[4] that provides guidance to staff at child residential and day treatment programs relating to the use of restraints.[5] Additionally, on February 1, 2006, the Department conducted a "kick-off" orientation seminar on this new policy. At the session, the Secretary of Public Welfare explained that DPW's goal is to eliminate the use of restraints. The Secretary acknowledged that implementation of such a policy is going to take resources, time, and training. She indicated that a change in thinking and culture in the licensed facilities will be required. She believes it will be a challenge, but the Secretary also stated that with commitment from everyone involved, she believes this goal can and will be achieved. The Secretary said there are many alternatives to using restraints.

The "special transmittal" document states that the use of restraint is a high risk, problem prone intervention for both children and staff and is to be avoided whenever possible because of the risk of serious injury and/or death of a child, youth, or staff; emotional harm and trauma to the child, youth, or staff; and the disruption of relationships between the youth, family members, peers, and provider staff.

Restraints are to be used only as an emergency measure of last resort in order to ensure the safety of all children and staff and only after appropriate, less restrictive behavioral techniques have been used. The goal is to prevent a child from injuring him/herself or others. DPW encourages the use of verbal and non-verbal de-escalation techniques by trained staff, such as reducing environmental stimuli, providing a quiet/comfort room, and allowing time for the individual to verbalize concerns instead of staff using restraints.

Inspection and Reporting Requirements

The federal Children's Health Act of 2000 requires providers to inform the Department of Health and Human Services (DHHS) of any death that was caused by the use of restraints or seclusion; deaths that occur while a patient is restrained or in seclusion; and deaths that occur within 24 hours after a patient is restrained. Failure to comply with these requirements will disqualify facilities from participation in any program supported in whole or in part by the Public Health Service Act.

As part of its licensing process, DPW inspects each facility for compliance with rules and regulations, including restraints regulations. We obtained DPW's inspection reports for CYs 2003, 2004, and 2005. There were two types of inspection forms included in these reports: one report is a comprehensive review of the facility's compliance with licensing regulations including restraints; and one report is used when reviewing restraint incident files only.

Using the comprehensive reports, we found that for 2003, there were 17 facility inspections. No facility fully met the restraints requirements; only one partially met the requirements and 16 did not meet the requirements. Reasons cited for not meeting the standards included failure of the physician to timely sign orders for holds and required debriefing sessions were either held late or not held at all. Additionally, in some instances it was unclear to the DPW reviewer as to who attended these debriefing sessions, and who notified the child's parent or guardian of the hold.

In 2004, there were eight inspections. One facility fully met the restraints requirements and seven facilities did not meet the requirements. Reasons cited for not meeting the requirements were similar to those cited in 2003. In 2005, there were ten inspections. None of the

Appendix E (Continued)

facilities met the requirements, and the reasons for noncompliance were similar to those for 2003 and 2004.

The second report form is specifically for a review of facility restraint incident files. The form seeks information on (1) whether or not the file documents who ordered the hold; (2) if the hold was verbally ordered; (3) whether or not a physician timely signed the verbal order for the hold; (4) whether there was a face to face assessment of the well-being of the resident within one hour of the hold release; (5) whether there was a face to face debriefing with the staff involved in the hold and the resident within 24 hours of the hold release; (6) whether there was a staff debriefing within 24 hours of the hold release; and (7) whether the parent/guardian was properly and timely notified of the hold.

In 2003, the DPW reviewer examined 67 incidences of restraints at one facility.[6] In 64 of the 67 cases, the requirements for properly ordering the hold and client assessments were met; in 62 of the 67 cases, staff debriefings were properly documented; and in 61 of the 67 cases, parents were properly notified of the hold.

In 2004, at one facility 121 holds were reviewed.[7] Of these, 100 files showed that the parents were properly notified of the hold; in 103 cases verbal orders for the hold were properly signed; and none of the files documented that either client or staff debriefings occurred as required.

Also in 2004, at one facility four holds were reviewed.[8] Only one hold file documented that a face-to-face staff-to-client debriefing occurred in that case. None of the other requirements were met in that case, and none of the other three holds met any of the requirements as documented in the files.

In another example, in 2005, 118 hold files were reviewed at one facility.[9] In 98 of the files, the standard of having the physician sign verbal orders was met. The standard that requires a face to face assessment of the resident within 24 hours of the end of the hold was met 114 times. The standard that requires a face-to-face staff/resident debriefing within 24 hours was met in 111 of the 118 cases.

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[1] In July 2004, PP&A sent a similar letter to the secretary. Additionally, the director of PP&A's Children's Project proposed a definition of "restraints free" to a task force working on this issue.

[2] No reports were received from the eastern or northeastern areas.

[3] As of late February 2006, these deaths were under investigation by authorities.

[4] This "special transmittal" is dated January 30, 2006.

[5] The Department of Public Welfare's Office of Mental Health and Substance Abuse issued a Mental Health and Substance Abuse Bulletin (OMHSAS-02-01) on April 8, 2002, that provides guidance to mental health facilities in moving toward a restraints-free environment.

[6] For the time period June 1, 2003, through September 16, 2003.

[7] For the time period April 1, 2004, through September 28, 2004.

[8] For the time period January 27, 2004, through February 25, 2004.

[9] For the time period October 2004 through April 2005.

Source: LB&FC staff review of 55 Pa. Code §3800.201 - §3800.213, the restraints Special Transmittal, the federal Children's Health Act of 2000, DPW inspection reviews and other related material.

APPENDIX F

Sample of Model Programs

Programs recognized as *effective substance abuse and mental health programs* by the United States Department Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), and as *effective in reducing adolescent violent crime, aggression, delinquency, and substance abuse* by the Center for the Study and Prevention of Violence (CSPV), a research program of the Institute of Behavioral Science at the University of Colorado at Boulder.

Midwestern Prevention Project (MPP) CSPV

- MMP is a comprehensive, community-based, multi-faceted program for adolescent drug abuse prevention. The MPP involves an extended period of programming. Although initiated in a school setting, it goes beyond this setting into the family and community contexts.

Big Brothers Big Sisters of America (BBBSA) CSPV

- BBBSA has been providing adult support and friendship to youth for nearly a century. A report in 1991 demonstrates that through BBBSA's network of nearly 500 agencies across the country, more than 70,000 youth and adults were supervised in one-to-one relationships.

Functional-Family Therapy (FFT) CSPV

- FFT is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes.

Life Skills Training (LST) CSPV & SAMHSA

- The results of over a dozen studies consistently show that the LST program dramatically reduces tobacco, alcohol, and marijuana use. These studies further show that the program works with a diverse range of adolescents, produces results that are long-lasting, and is effective when taught by teachers, peer leaders, or health professionals.

Multisystemic Therapy (MST) CSPV & SAMHSA

- MST is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extra-familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems.

Nurse-Family Partnership (NFP) CSPV & SAMHSA

- NFP (Formerly Prenatal and Infancy Home Visitation by Nurses), guided by a strong theoretical orientation, consists of intensive and comprehensive home visitation by nurses during a woman's pregnancy and the first two years after birth of the woman's first child. While the primary mode of service delivery is home visitation, the program depends upon a variety of other health and human services in order to achieve its positive effects.

Multidimensional Treatment Foster Care (MTFC) CSPV

- MTFC is a cost effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. Community families are recruited, trained, and closely supervised to provide MTFC-placed adolescents with treatment and intensive supervision at home, in school, and in the community; clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; and separation from delinquent peers.

Olweus Bullying Prevention Program (BPP) CSPV & SAMHSA

- BBP is a universal intervention for the reduction and prevention of bully/victim problems. The main arena for the program is the school, and school staff has the primary responsibility for the introduction and implementation of the program.

The Incredible Years: Parent, Teacher and Child Training Series (IYS) CSVP & SAMHSA

- IYS is a set of three comprehensive, multi-faceted, and developmentally-based curriculums for parents, teachers, and children designed to promote emotional and social competence and to prevent, reduce, and treat behavior and emotion problems in young children.

Appendix F (Continued)

Promoting Alternative Thinking Strategies (PATHS) CSPV & SAMHSA

- PATHS (Promoting Alternative Thinking Strategies) Curriculum is a comprehensive program for promoting emotional and social competencies and reducing aggression and behavior problems in elementary school-aged children while simultaneously enhancing the educational process in the classroom. This innovative curriculum is designed to be used by educators and counselors in a multi-year, universal prevention model. Although primarily focused on the school and classroom settings, information and activities are also included for use with parents.

Project Toward No Drug Abuse (Project TND) CSVP & SAMHSA

- Project TND is an effective drug abuse prevention program that targets heterogeneous samples of high school-age youth. Reductions in cigarette smoking, alcohol use, marijuana use, hard drug use, and victimization have been revealed at one- and two-year follow-up periods.

Brief Alcohol Screening and Intervention for College Students (BASICS) CSVP & SAMHSA

- A Harm Reduction Approach, BASICS is a preventive intervention for college students 18 to 24 years old. It is aimed at students who drink alcohol heavily and have experienced or are at risk for alcohol-related problems such as poor class attendance, missed assignments, accidents, sexual assault, and violence.

Creating Lasting Family Connections (CLFC) SAMHSA

- CLFC is a comprehensive family strengthening, substance abuse, and violence prevention curriculum that has scientifically demonstrated that youth and families in high-risk environments can be assisted to become strong, healthy, and supportive people. Program results, documented with children 11 to 15 years, have shown significant increases in children’s resistance to the onset of substance use and reduction in use of alcohol and other drugs. CLFC provides parents and children with strong defenses against environmental risk factors by teaching appropriate skills for personal growth, family enhancement, and interpersonal communication, including refusal skills for both parents and youth.

Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA) SAMHSA

- CBT-CSA is designed to help children and adolescents who have suffered sexual abuse overcome posttraumatic stress disorder (PTSD), depression, and other behavioral and emotional difficulties. The program helps children to learn about sexual abuse as well as healthy sexuality, process traumatic memories, overcome problematic thoughts, feelings, and behaviors, and develop effective coping and body safety skills. Cognitive behavioral methods are used to help parents learn to cope with their own distress and respond effectively to their children's behavioral difficulties.

Multidimensional Family Therapy (MDFT) SAMHSA

- MDFT is a family-based program designed to treat substance abusing and delinquent youth. MDFT is an intervention system that assesses and intervenes with the adolescent and parents individually; family as an interacting system; and individuals in the family, relative to their interactions with influential social systems (e.g., school). Interventions strive to obtain immediate and practical outcomes in the everyday life of the adolescent.

Trauma Focused Cognitive Behavior Therapy (TF-CBT) SAMHSA

- TF-CBT is a treatment intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events. It was developed by integrating cognitive and behavioral interventions with traditional child abuse therapies, in order to focus on enhancing children's interpersonal trust and re-empowerment. TF-CBT can be provided to children 3 to 18 years old, and their parents, by trained mental health professionals in individual, family, and group sessions in outpatient settings. The intervention also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior.

For additional information concerning these programs, or for additional programs, visit the SAMHSA Model Programs website at *http://modelprograms.samhsa.gov* and the Blueprints for Violence Prevention, Center for the Study and Prevention of Violence at *http://www.colorado.edu/cspv/*.

APPENDIX G

MacArthur Foundation's Models for Change Initiative: Pennsylvania

The Models for Change Initiative focuses on these three areas in Pennsylvania:

- *Aftercare*: The goal of reform efforts in this area is to improve aftercare services and supervision so that every young offender has a smooth and successful re–entry after being in a juvenile justice placement. If the initiative is successful, each youth in placement will have a high–quality aftercare plan that is completed in a timely fashion and properly implemented. The residential facility's treatment plan will be integrated with the aftercare plan to prepare the young person for life after confinement. The residential facility's staff will coordinate planning with the aftercare probation officer. Services will be available in the community that can support the plan.
- *Disproportionate Minority Contact*: The initial reform goals in this targeted area are to move Pennsylvania toward becoming a model of DMC data collection and to use the data collected to bring about needed change.
- *Mental Health/Juvenile Justice Coordination*: The goal of the initiative in this area will be to improve the coordination of and access to mental health services for court–involved young people in Pennsylvania. (See the following sections for more information regarding the Mental Health/Juvenile Justice Coordination of the Models for Change Initiative.)

While work toward this initiative is focused at the statewide level, pilot projects have been instituted in eight counties: Philadelphia, Cambria, York, Lycoming, Berks, Chester, Allegheny, and Erie. The goals of these counties will be working to accomplish:

County	Mental Health Focus/Emphasis Area
Philadelphia	Disproportionate Minority Contact, Aftercare
Erie	Mental Health
Chester	Mental Health
Allegheny	Disproportionate Minority Contact, Aftercare, Mental Health
Cambria	Aftercare
York	Aftercare
Lycoming	Aftercare
Berks	Disproportionate Minority Contact

Mental Health and Juvenile Justice Coordination. The Education Law Center and the JCJC have targeted the coordination between the juvenile justice and youth mental health systems because the mental health needs of juvenile offenders are not being met. Efforts will focus on:

- Collaborations at the state and county levels among the agencies responsible for youth with mental health problems in the child welfare and juvenile justice systems.

Appendix G (Continued)

- Creation of interagency teams to expedite placement of youth into appropriate programs.
- Adoption of a single multi-system screening and assessment instrument for all young offenders.
- Promulgation of policies to reduce contact with the juvenile justice system for youth with mental health needs and divert them into community-based programs.
- Development of blended or integrated funding strategies.
- Delivery of evidence-based practices and programs.

The overall goal is to improve the coordination and access to mental health services for court-involved youth. Possible outcomes could include increased numbers of court-involved youth who have mental health disorders being treated outside the juvenile justice system and increased access to appropriate and effective mental health programs and services. Improvements in access to mental health services will help keep youth out of delinquency placements and provide youth with more and better resources when they leave residential care.

Mental Health/Juvenile Justice Joint Position Paper. To further the coordination between the mental health and juvenile justice systems, a committee was designated to draft a joint position statement with the intention of having it endorsed by department heads of state agencies and statewide organizations, and then assign specific goals in the position statement to subcommittees. This position paper was released to the signatories in January 2006 with the goal that by 2010, every county will have a comprehensive model system that:

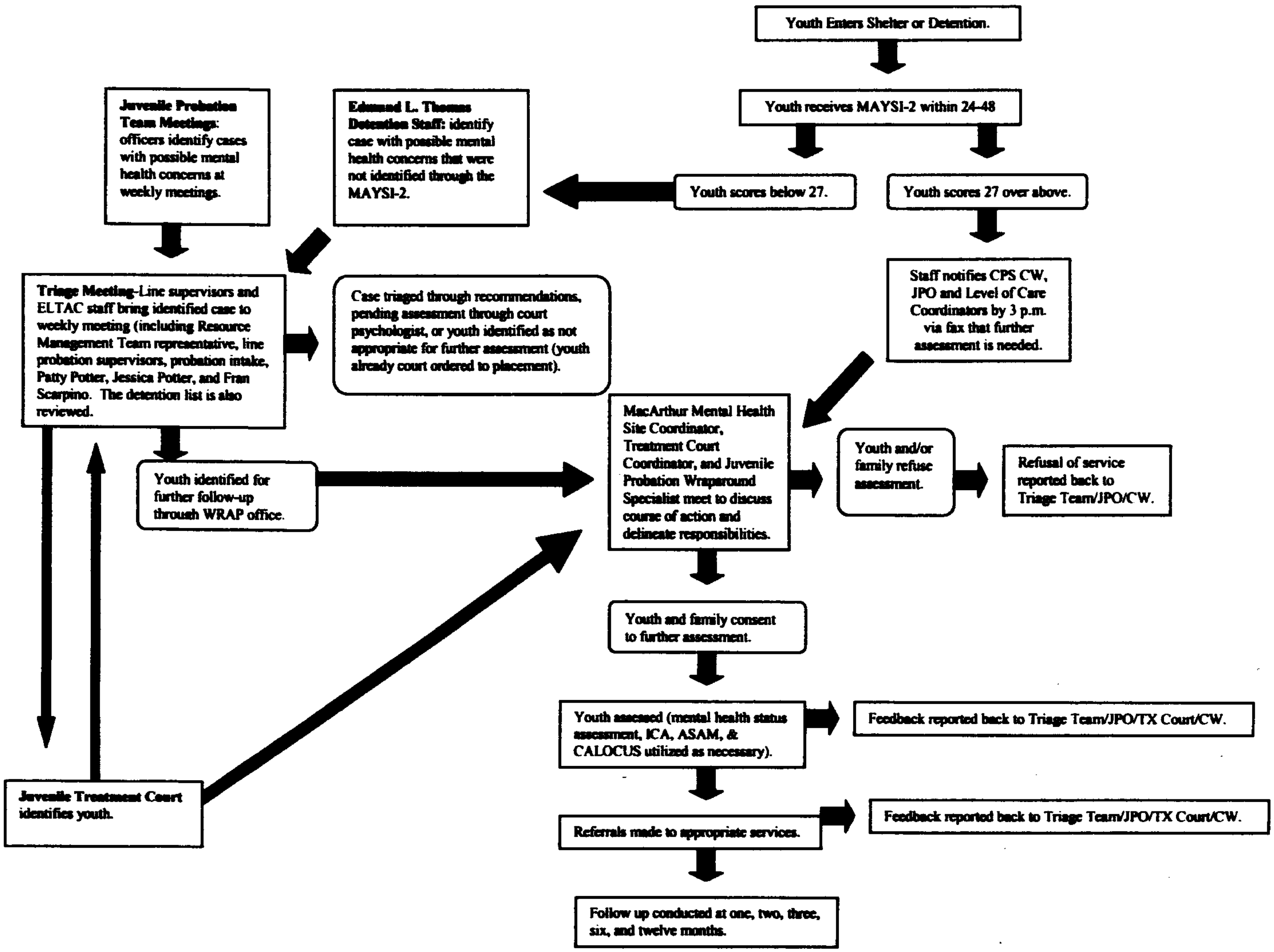
- prevents unnecessary involvement of youth with mental health disorders, including those with co-occurring substance abuse disorders, in the juvenile justice system;
- allows for early identification of youth in the system with mental health needs and co-occurring disorders; and
- provides for timely access by identified youth in the system to appropriate treatment within the least restrictive setting that is consistent with public safety needs.

The position paper also recognizes that cross-systems collaboration is necessary to achieve their goal because no one system bears the responsibility for these youth.

Source: Developed by LB&FC staff from MacArthur Work Group documents.

APPENDIX H

Erie County Mental Health & Juvenile Justice Service Flowchart



APPENDIX I

HealthChoices MA Expenditures Per Recipient, Ages 0-17, for Selected Mental Health Services

(CY 2004)

County	Inpatient Psychiatric Hospital (Not SMH)	Psychiatric Partial Hospitalization	Psychiatric Outpatient Clinic	BHRS and Co-Occurring	Residential Treatment (JCAHO)	Residential Treatment (Non-JCAHO)	Crisis Intervention w/In-Home Capability	Family-Based MH Services	Targeted Case Mgmt., Intensive Case Mgmt., & Resource Coord.
Adams	$ 6,775	$3,114	$435	$10,321	$32,557	$16,624	$ 16	$ 7,667	$1,333
Allegheny	8,246	5,082	504	10,012	37,377	8,682	656	8,694	2,432
Armstrong	6,032	4,162	314	9,865	33,404	28,371	203	7,601	1,458
Beaver	5,323	2,352	266	8,815	43,505	4,155	76	8,454	2,138
Berks	11,414	4,425	468	7,320	38,832	15,242	112	9,981	1,167
Bucks	5,663	2,195	390	6,473	35,116	44,182	0	10,051	2,433
Butler	7,343	2,450	335	6,686	36,061	35,984	54	8,198	1,373
Chester	7,466	5,241	564	7,814	35,107	27,033	238	10,742	2,081
Cumberland	7,834	2,915	431	10,836	38,725	39,317	238	13,645	2,133
Dauphin	6,892	2,707	409	8,545	48,449	23,693	132	12,620	1,381
Delaware	7,685	1,537	317	10,137	42,165	52,275	110	7,234	2,180
Fayette	4,461	5,800	447	5,913	27,797	20,633	92	5,778	1,274
Greene	5,323	5,668	328	5,972	36,887	11,815	63	7,308	1,325
Indiana	6,523	4,445	422	9,906	34,913	32,388	201	8,428	2,526
Lancaster	7,038	1,747	468	8,584	42,301	19,483	134	12,135	1,507
Lawrence	3,549	4,268	393	9,050	37,457	32,931	66	5,673	2,842
Lebanon	6,122	1,104	358	10,285	43,431	39,393	113	11,510	1,464
Lehigh	8,810	4,829	167	9,959	44,284	13,183	69	7,129	1,977
Montgomery	8,610	5,473	213	6,737	41,545	42,388	30	8,877	1,915
Northampton	7,793	4,823	112	6,861	40,329	52,427	126	7,853	1,681
Perry	6,812	4,154	434	7,785	44,326	25,890	323	17,227	3,140
Philadelphia	7,987	4,489	735	13,457	43,239	40,185	0	2,089	2,759
Washington	6,565	6,766	338	8,058	26,371	17,791	28	8,206	1,508
Westmoreland	5,953	6,253	362	12,713	34,961	28,298	266	8,190	1,571
York	10,532	4,317	410	7,988	35,601	21,028	50	10,165	1,407

Source: Developed by LB&FC staff using information obtained from OMHSAS CY 2004 Service Utilization report.

APPENDIX J

Fee-for-Service MA Expenditures Per Recipient, Ages 0–17, for Selected Mental Health Services

(CY 2003)

County	Inpatient Psychiatric Hospital (Not SMH)	Psychiatric Partial Hospitalization	Psychiatric Outpatient Clinic	BHRS and Co-Occurring	Residential Treatment (JCAHO)	Residential Treatment (Non-JCAHO)	Crisis Intervention w/In-Home Capability	Family-Based MH Services	Targeted MH Case Mgmt., Intensive Case Mgmt. & Resource Coord
Adams.............	$ 4,379	$4,294	$314	$ 3,510	$30,009	$ 6,106	$ 0	$ 0	$ 107
Allegheny.........	9,248	2,916	110	5,357	22,271	4,823	52	2,024	558
Armstrong	15,795	5,082	160	3,559	21,704	0	22	3,155	300
Beaver	5,807	1,335	167	6,251	0	0	0	1,121	608
Bedford	5,960	5,707	181	11,658	38,622	0	23	3,877	626
Berks...............	13,992	1,692	200	4,048	25,213	6,355	28	1,432	140
Blair.................	7,045	5,825	246	9,636	58,571	22,681	81	4,320	591
Bradford	5,971	5,407	236	4,317	46,285	6,588	91	4,027	0
Bucks	5,871	2,347	270	1,268	52,669	0	0	2,414	466
Butler	7,424	1,185	151	2,935	40,648	0	38	1,806	150
Cambria	5,395	5,806	234	12,779	40,386	31,083	64	3,612	453
Cameron	16,162	2,963	236	2,670	53,088	0	20	5,745	1,311
Carbon	8,961	5,797	202	8,502	47,993	9,662	18	1,948	748
Centre	6,093	4,476	331	8,010	60,324	0	108	4,538	1,273
Chester	6,136	2,891	155	2,579	41,440	0	0	1,290	292
Clarion	10,100	2,146	221	10,577	75,270	0	39	3,806	749
Clearfield	6,717	4,101	448	13,049	57,552	0	146	4,279	788
Clinton.............	7,040	3,865	268	6,112	44,950	0	39	1,205	1,206
Columbia	6,818	6,443	155	5,813	64,900	0	18	1,772	638
Crawford	8,202	5,529	164	12,940	70,940	26,348	170	4,258	680
Cumberland	6,946	1,793	218	3,510	23,154	0	106	4,558	438
Dauphin	6,272	4,651	170	2,213	35,237	0	91	2,342	285
Delaware	6,603	6,357	264	1,734	37,459	0	5	2,540	167
Elk...................	7,266	4,531	248	8,736	44,675	0	5	3,673	640
Erie	5,837	6,931	223	7,970	53,996	3,039	135	3,285	1,315
Fayette............	4,871	2,028	103	5,820	62,810	0	57	1,652	424
Forest..............	25,113	1,215	290	9,182	54,393	0	0	7,561	188
Franklin	6,618	4,032	292	11,283	48,931	0	123	1,605	717
Fulton	4,593	2,775	304	8,643	29,185	0	0	2,890	903
Greene............	6,033	3,275	206	260	17,917	10,244	14	1,591	0
Huntingdon	6,973	4,246	282	8,191	69,565	0	15	3,707	603
Indiana	12,627	3,333	134	4,320	34,700	0	313	2,240	701

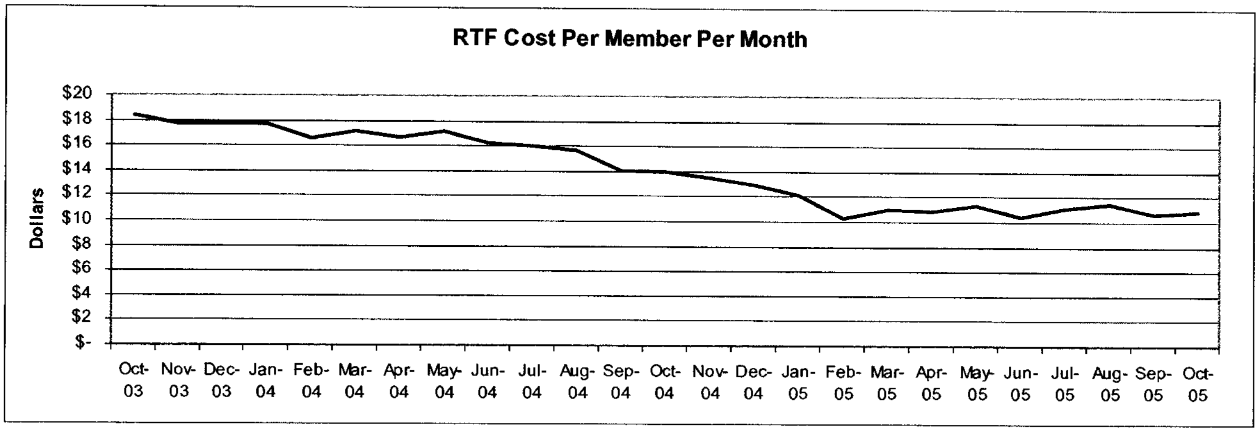
Appendix J (Continued)

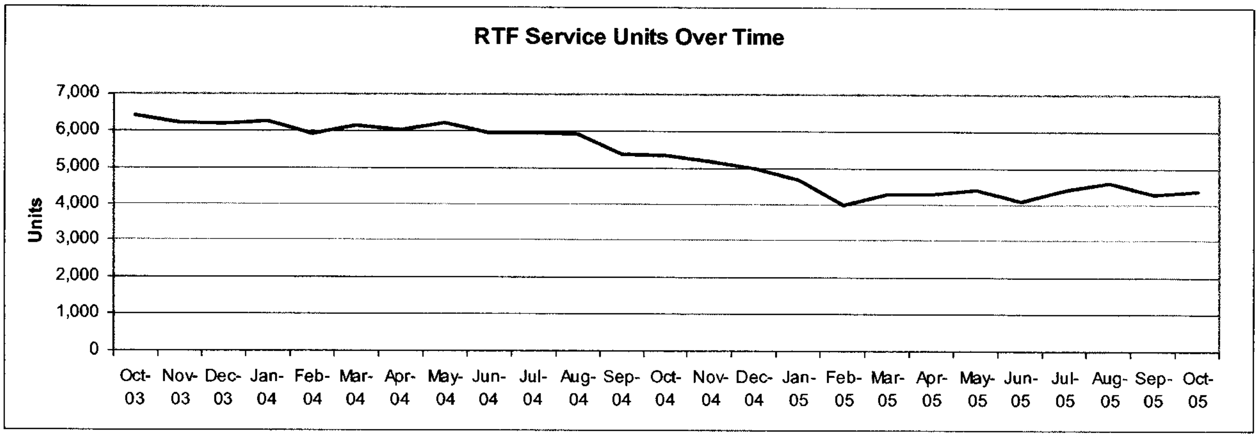
County	Inpatient Psychiatric Hospital (Not SMH)	Psychiatric Partial Hospitalization	Psychiatric Outpatient Clinic	BHRS and Co-Occurring	Residential Treatment (JCAHO)	Residential Treatment (Non-JCAHO)	Crisis Intervention w/In-Home Capability	Family-Based MH Services	Targeted MH Case Mgmt., Intensive Case Mgmt. & Resource Coord
Jefferson	$ 6,721	$ 3,435	$ 299	$11,482	$55,572	$26,045	$ 132	$5,351	$ 295
Juniata	7,338	4,181	148	4,804	24,315	0	31	3,265	1,044
Lackawanna	9,293	6,294	244	7,500	54,685	17,632	64	2,580	938
Lancaster	9,914	3,849	198	2,964	24,712	3,798	133	1,711	160
Lawrence	6,494	1,688	264	5,534	0	18,713	26	925	1,244
Lebanon	4,918	525	138	6,793	33,981	0	22	1,570	448
Lehigh	11,474	2,352	219	8,881	22,183	16,842	364	1,517	222
Luzerne	9,681	3,941	186	8,591	43,554	13,769	162	2,591	1,397
Lycoming	8,593	6,448	303	6,618	50,057	0	201	2,254	709
McKean	10,916	3,792	193	7,284	56,540	0	67	2,961	784
Mercer	5,503	2,128	355	14,118	83,339	23,188	138	3,184	472
Mifflin	6,195	3,630	264	6,575	41,801	4,440	48	4,244	820
Monroe	13,103	4,799	152	6,939	47,926	0	56	3,081	797
Montgomery	9,662	3,177	169	1,364	40,109	2,770	66	1,570	360
Montour	2,593	8,790	139	8,273	41,080	0	8	436	652
Northampton	8,505	2,711	426	14,459	41,804	3,319	83	625	229
Northumberland	5,457	6,181	272	5,847	42,192	0	96	3,659	721
Perry	3,027	510	198	3,701	0	4,497	0	0	482
Philadelphia	10,363	4,412	200	2,146	36,679	5,982	153	722	317
Pike	11,566	4,535	123	7,224	24,042	0	45	3,011	966
Potter	6,666	1,678	186	8,925	30,137	0	98	3,470	135
Schuylkill	7,269	4,411	285	7,045	38,289	10,234	100	3,128	589
Snyder	5,660	5,145	228	6,291	45,841	0	24	1,337	630
Somerset	6,500	6,655	222	13,118	68,707	26,554	38	3,732	767
Sullivan	15,331	5,013	208	1,578	87,730	0	79	1,928	0
Susquehanna	7,835	4,973	189	7,489	40,244	0	75	2,920	1,244
Tioga	6,314	2,104	281	9,255	62,028	5,878	74	2,681	1,060
Union	7,941	7,374	218	8,348	57,664	0	20	5,314	528
Venango	10,834	1,574	198	6,936	60,735	37,678	136	3,465	299
Warren	7,133	4,619	216	9,428	60,427	20,662	0	4,826	807
Washington	5,327	8,415	148	5,461	32,476	0	14	2,268	335
Wayne	11,399	4,938	205	5,824	48,851	0	66	2,577	985
Westmoreland	3,775	2,739	116	9,196	0	0	77	1,869	361
Wyoming	7,632	2,534	173	10,307	61,970	0	161	2,834	1,142
York	5,285	2,603	275	7,159	42,417	27,726	11	840	299

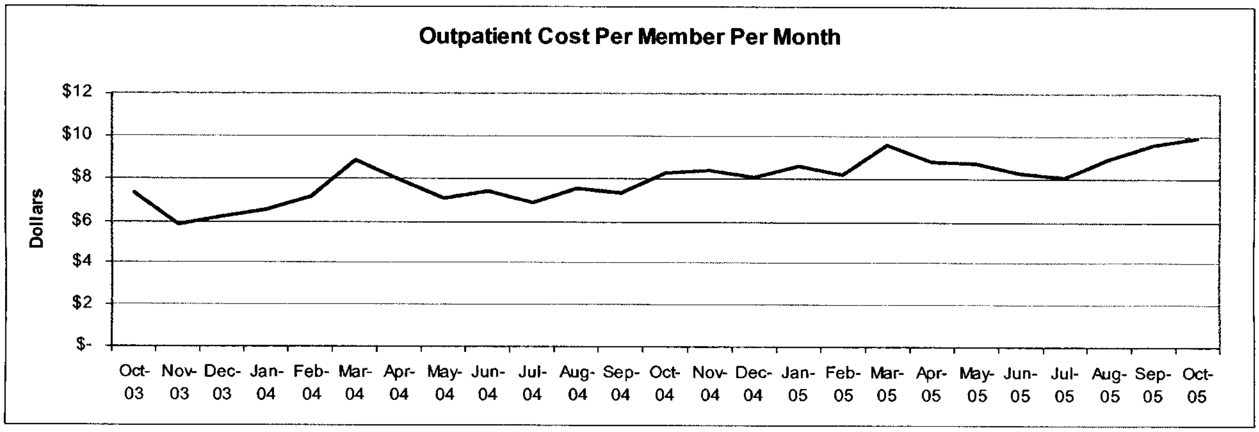
Source: Developed by LB&FC staff using information obtained from OMHSAS CY 2003 Service Utilization report.

APPENDIX K

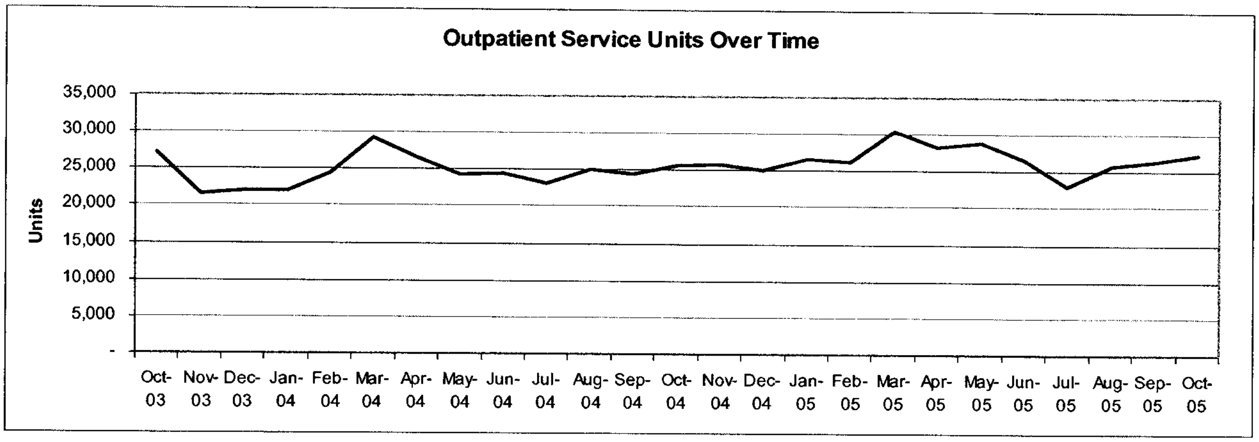
CBHNP Per Member Per Month Costs and Service Delivery for Selected Service Categories

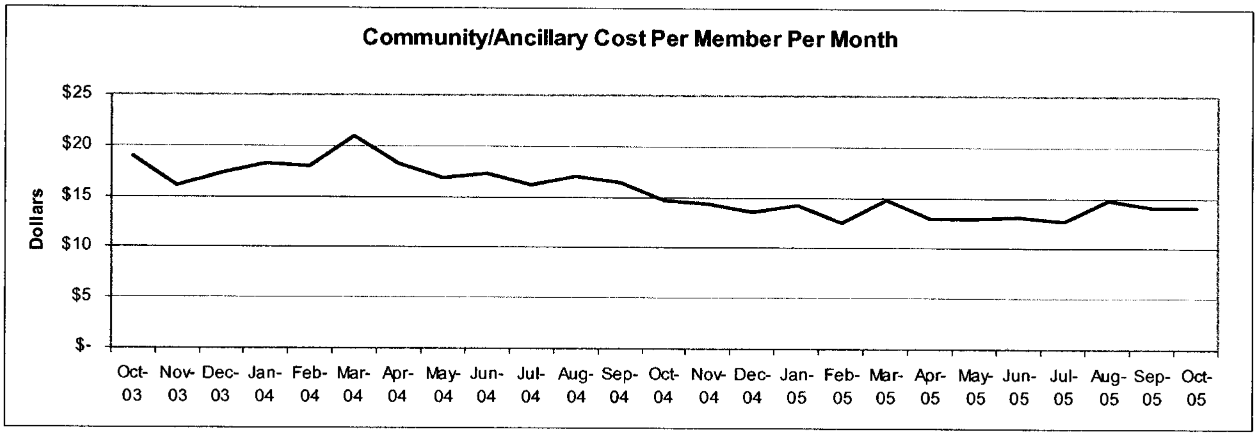


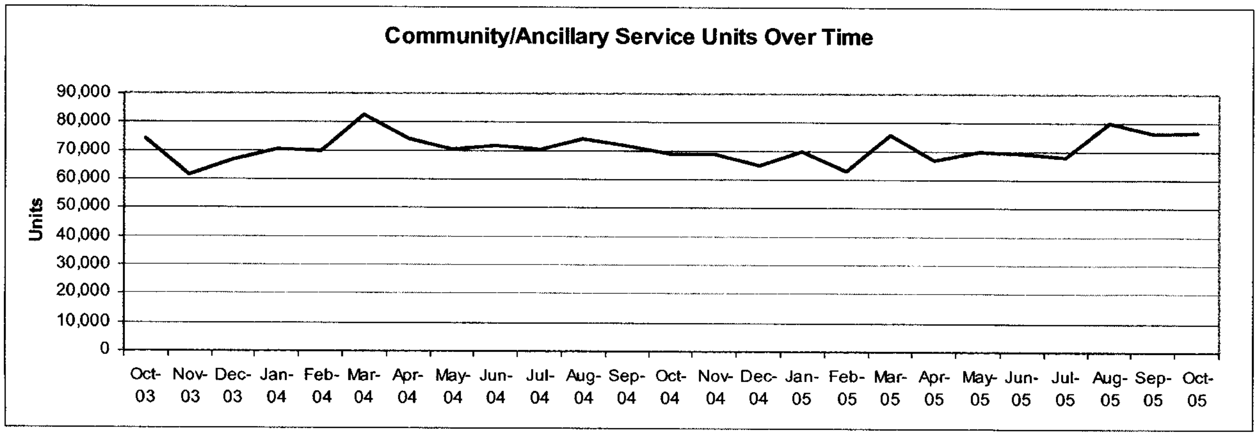




Appendix K (Continued)







Source: Developed by LB&FC staff from information provided by CBHNP.

APPENDIX L

DPW's Office of Medical Assistance Programs Encounter Form

PROVIDER NAME

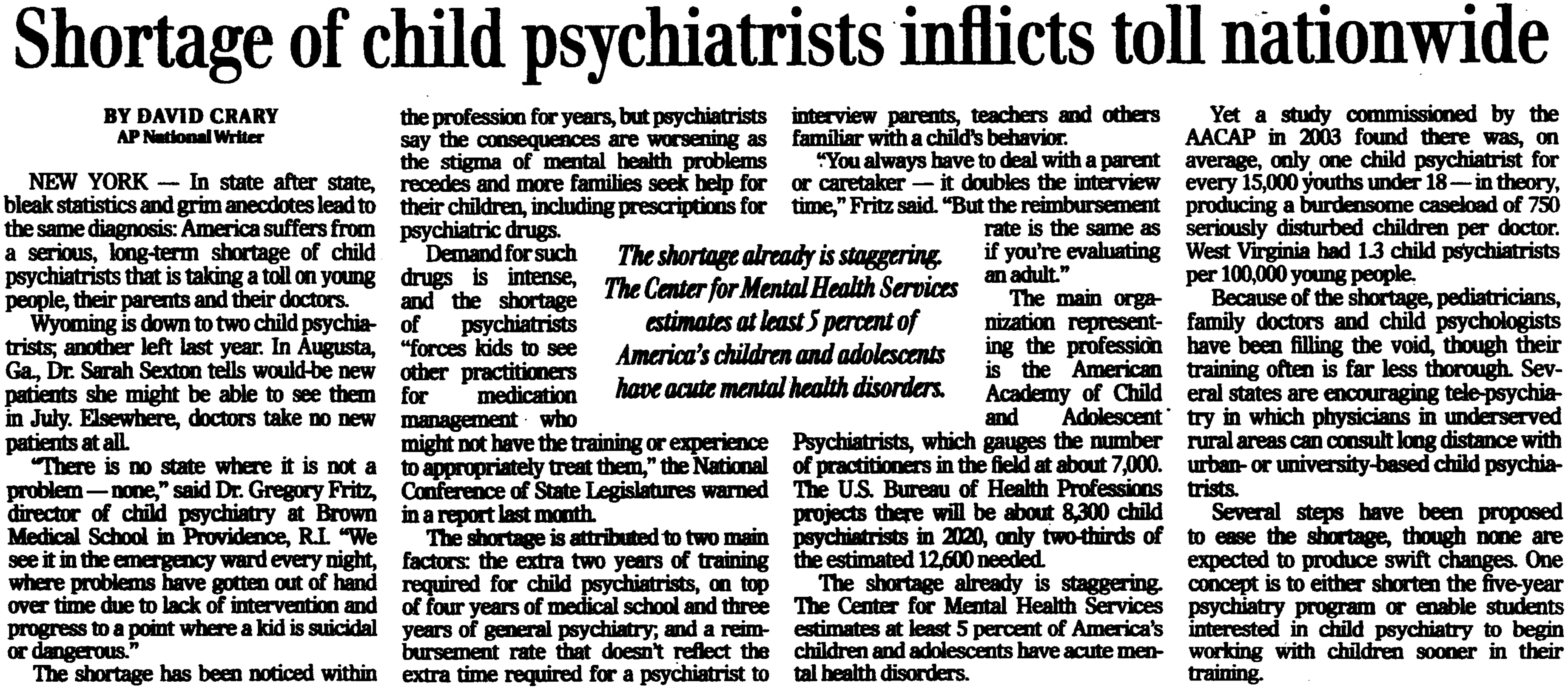
PROVIDER MAID NUMBER

ADDRESS

"My signature certifies that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws."

DATE	RECIPIENT NUMBER	RECIPIENT'S SIGNATURE I have read and agree with the above statement.

APPENDIX M



Shortage of child psychiatrists inflicts toll nationwide

BY DAVID CRARY
AP National Writer

NEW YORK — In state after state, bleak statistics and grim anecdotes lead to the same diagnosis: America suffers from a serious, long-term shortage of child psychiatrists that is taking a toll on young people, their parents and their doctors.

Wyoming is down to two child psychiatrists; another left last year. In Augusta, Ga., Dr. Sarah Sexton tells would-be new patients she might be able to see them in July. Elsewhere, doctors take no new patients at all.

"There is no state where it is not a problem — none," said Dr. Gregory Fritz, director of child psychiatry at Brown Medical School in Providence, R.I. "We see it in the emergency ward every night, where problems have gotten out of hand over time due to lack of intervention and progress to a point where a kid is suicidal or dangerous."

The shortage has been noticed within the profession for years, but psychiatrists say the consequences are worsening as the stigma of mental health problems recedes and more families seek help for their children, including prescriptions for psychiatric drugs.

Demand for such drugs is intense, and the shortage of psychiatrists "forces kids to see other practitioners for medication management who might not have the training or experience to appropriately treat them," the National Conference of State Legislatures warned in a report last month.

The shortage already is staggering. The Center for Mental Health Services estimates at least 5 percent of America's children and adolescents have acute mental health disorders.

The shortage is attributed to two main factors: the extra two years of training required for child psychiatrists, on top of four years of medical school and three years of general psychiatry; and a reimbursement rate that doesn't reflect the extra time required for a psychiatrist to interview parents, teachers and others familiar with a child's behavior.

"You always have to deal with a parent or caretaker — it doubles the interview time," Fritz said. "But the reimbursement rate is the same as if you're evaluating an adult."

The main organization representing the profession is the American Academy of Child and Adolescent Psychiatrists, which gauges the number of practitioners in the field at about 7,000. The U.S. Bureau of Health Professions projects there will be about 8,300 child psychiatrists in 2020, only two-thirds of the estimated 12,600 needed.

The shortage already is staggering. The Center for Mental Health Services estimates at least 5 percent of America's children and adolescents have acute mental health disorders.

Yet a study commissioned by the AACAP in 2003 found there was, on average, only one child psychiatrist for every 15,000 youths under 18 — in theory, producing a burdensome caseload of 750 seriously disturbed children per doctor. West Virginia had 1.3 child psychiatrists per 100,000 young people.

Because of the shortage, pediatricians, family doctors and child psychologists have been filling the void, though their training often is far less thorough. Several states are encouraging tele-psychiatry in which physicians in underserved rural areas can consult long distance with urban- or university-based child psychiatrists.

Several steps have been proposed to ease the shortage, though none are expected to produce swift changes. One concept is to either shorten the five-year psychiatry program or enable students interested in child psychiatry to begin working with children sooner in their training.

Source: *Intelligencer Journal,* Lancaster, PA, Friday, April 7, 2006.

APPENDIX N

Excerpts From LB&FC February 2003 Report:
Drug and Alcohol Treatment Services in a Managed Care Environment

PA Drug and Alcohol Abuse Act. The Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. §1690.101 et seq., requires that all patient records remain confidential, subject to the following exceptions:

- disclosure may occur with the patient's consent, but only to medical personnel exclusively for purposes of diagnosis and treatment of the patient, or
- to government or other officials exclusively for the purpose of obtaining benefits due the patient as a result of his drug or alcohol abuse or drug or alcohol dependence (except emergency medical situations).

The act also provides that a complete medical, social, occupational, and family history must be obtained as part of the diagnosis, classification, and treatment of a patient pursuant to this act. Copies of all pertinent records from other agencies, practitioners, institutions, and medical facilities must be obtained in order to develop a complete and permanent confidential personal history for purposes of the patient's treatment.

Department of Health regulations (4 Pa. Code §255.5) further clarify the information that can be released on persons receiving drug and alcohol treatment services. Section 255.5 restricts the information that can be released (upon client consent) to an insurance company or health or hospital plan to the following five items:

- Whether the client is or is not in treatment.
- The prognosis of the client.
- The nature of the project.
- A brief description of the progress of the client.
- A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

In 1997, it was brought to the attention of the Department's Division of Drug and Alcohol Program Licensing that its licensing inspectors were identifying treatment facilities that were violating confidentiality regulations in annual field reviews. The providers complained, noting that at the second level appeal of a denial, managed care organizations often require the patient's full charts and/or medical records to continue the process. If the substance abuse provider does not supply this information, services could be denied or the BHCO could later refuse to pay for the services provided.[1]

In an attempt to remedy this situation, in July 1997, the Department's Deputy Secretary for Quality Assurance issued a letter of interpretation stating as follows:

> *Whether the Client Is or Is Not in Treatment* – Information may be released as to how long the client has been in treatment; how long the client is expected to stay in treatment; and the attendance patterns of the client.
> *Client's Prognosis* – Information may be released as to the client's prognosis/diagnosis; how treatment will or will not benefit the client; and whether the client should continue with the project.
> *Nature of the Project* – Information may be released as to the purpose and philosophy of the project; program structure, methodology of treatment and the treatment models that are utilized by the project; and services that are being offered to an individual client.
> *Brief Description of the Client's Progress* – Information may be released as to the client's denial or lack of denial and client's progress in coming to terms with his/her addiction; the client's cooperation or lack of cooperation with treatment plan and the facility's rules.
> *Short Statement as to Whether the Client Has Relapsed Into Drug or Alcohol Abuse and the Frequency of Such Relapse* – Information may be released that provides a short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse; and results of urine tests.

As discussed below, however, this letter has done little to resolve the problem, in part because the language in Act 1998-68 would appear to permit broader disclosures.

Act 68. Act 1998-68 provides that a managed care plan shall adopt and maintain procedures to ensure that all identifiable information regarding enrollee health, diagnosis, and treatment is adequately protected and remains confidential in compliance with all applicable federal and state laws and regulations and professional ethical standards. The act goes on to provide, however, that nothing in the confidentiality section is to prevent disclosure by the MCO of the information "necessary to determine coverage, review complaints or grievances, conduct utilization review or facilitate payment of a claim."

Discussion. Magellan Behavioral Health, through its counsel, has sought clarification from the Department of Health as to the interpretation and applicability of regulation at §255.5 in light of the newer provisions of Act 68. Magellan's position is that the restrictions of §255.5 prevent them from obtaining sufficient information to comply with the newer requirements of Act 68, such as (1) making determinations of "medical necessity," (2) being able to timely address complaints and grievances, (3) undertaking quality improvements, and (4) report on their activities to the Department. Magellan concludes that §255.5 is superceded either by Act 68 or, at a minimum, is no longer workable in light of the managed care structure of health care and actually impedes the organized management of care. No response to the Magellan request for clarification had been issued by the Department as of December 2002.[2] The Department began meeting with stakeholder groups in 2002 to work on issues relating to §255.5 and anticipates issuing a new letter of interpretation in 2003.

In addition to the conflicts created between substance abuse providers and BHCOs, the confidentiality requirements make integrated care more difficult to provide for the dually diagnosed. For example, a Philadelphia facility reported that it may use two providers to treat the same clients for mental illness and substance abuse, but communication between the different providers is, at least technically, a violation of the confidentiality restrictions. One suggested solution was to exempt clients with certain co-morbidities from the confidentiality restrictions.

One group of utilization review coordinators we spoke with stated they generally comply with 4 Pa. Code §255.5(b) when they release patient information to BHCOs. They make only the five approved items available for utilization review but share complete information with other health care treatment providers. Utilization reviewers may, however, look at the patient's charts on site. Other providers indicated that they need to disclose confidential information before the BHCO will decide on medical necessity and approve treatment.[3]

Federal Provisions

With certain exceptions, federal confidentiality laws and regulations prohibit disclosure of information about patients who have applied for or received any alcohol or drug abuse-related services. Federally regulated or assisted drug and alcohol functions must maintain the confidentiality of all records of identity, diagnosis, prognosis, or treatment of any patient.[4] Disclosure[5] may be made as follows:

- with prior written client consent for purposes set forth in regulation; and
- without client consent to (1) medical personnel for a bona fide medical emergency; (2) qualified personnel for scientific research, management audits, financial audits, or program evaluations, as long as individual information is not disclosed; and (3) based on court orders.

Appendix N (Continued)

The federal requirements do not preempt state laws or regulations. Therefore, a more restrictive state requirement regarding confidentiality will take precedence over a less restrictive federal requirement.[6]

Federal HIPAA Regulations

In August 2002, the U.S. Department of Health and Human Services issued the first-ever comprehensive federal regulation that gives patients extensive privacy protections for their medical records. The HIPAA privacy rule applies to health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions electronically. Under the new regulation (effective on April 14, 2003), patients are guaranteed access to their medical records and are given more control over how their health information is used and disclosed, with recourse if their medical record privacy is violated. The rule provides that:

- patients must give specific authorization before covered health care entities could make non-routine use or disclosure of protected information;
- covered health care entities must give notice to patients of privacy practices and patients' rights;
- covered entities must get patient authorization before sending them marketing materials;
- covered entities cannot use business associate agreements to circumvent the rule's marketing prohibitions; and
- patients can generally access and request corrections to their medical records.

Covered entities, including most, if not all, substance abuse treatment providers, must comply with the new privacy regulations by April 14, 2003. However, federal regulations stipulate that if a state has imposed more rigorous requirements, the state requirements take precedence. Thus, Pennsylvania's state confidentiality requirements are stricter than HIPAA.

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[1] We were also told that confidentiality requirements are routinely compromised in some drug courts. One provider indicated they maintain separate files on disclosed confidential information that can be removed when representatives of the Department of Health review the files.

[2] We met jointly with DPW and DOH in mid-2002. They were continuing their discussions as of December 2002, but they had not completed their plans to address this matter.

[3] DOH reported, however, that it has not issued citations for failure to comply with confidentiality regulations.

[4] A "patient" is any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine eligibility to participate in a program. A "diagnosis" includes any reference to an individual's alcohol or drug abuse or a condition caused by that abuse made for treatment or referral. "Treatment" includes management and care of a patient suffering from alcohol or drug abuse, a condition caused by that abuse, or both to reduce or eliminate adverse effects upon that patient.

[5] A "disclosure" refers to a communication of patient identifying information, the affirmative verification of another person's communication of patient identifying information, or communication of any information from the record of a patient who has been identified. "Patient Identifying Information" means name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. It does not include a number assigned to a patient by a program.

[6] Federal regulations do permit exceptions for certain audit and evaluation activities or entities conducting audits on behalf of a state governmental agency that either provides financial assistance to the program or is authorized by law to regulate the program's activities.

Source: LB&FC report *Drug and Alcohol Treatment Services in a Managed Care Environment,* February 2003.

APPENDIX O

Act 147 of 2004 (Senate Bill 137) Age of Consent to Mental Health Treatment in Pennsylvania Preliminary Responses From the Office of Mental Health and Substance Abuse Services (OMHSAS), Bureau of Children's Services*

Although Act 147 directly affects mental health providers and agencies, there are no provisions in the act that give any state agency the authority to promulgate regulations specific to the act. The act will be codified as an amendment to P.L. 19, No. 10, entitled Minor's Consent to Medical, Dental, and Health Services. The act does not amend the Mental Health Procedures Act.

Because of the direct impact to mental health providers, OMHSAS is drafting a bulletin with the Department's interpretations in response to questions received from stakeholders regarding Act 147 of 2004 and its implementation. The following preliminary responses are being distributed to assist with implementation prior to the issuance of an OMHSAS bulletin.

Providers are advised to consult with their professional organizations and legal representation to ensure compliance with Act 147 and ensure its appropriate implementation.

Issue	Response
1. Will DPW develop a form for providers to use if the minor aged 14-17 objects to inpatient treatment? (A form is referenced in the act.)	DPW will issue suggested draft language for the petition form referenced in the act if a minor objects to inpatient treatment consented to by a parent/legal guardian.
2. According to Act 147, can a minor who is 14 years of age or older consent to inpatient or outpatient mental health treatment without their parent/legal guardian's consent?	Yes
3. According to Act 147, can a parent/legal guardian consent to inpatient or outpatient mental health treatment for a minor aged 14-17 without the minor's consent?	Yes
4. Does the minor's consent to mental health treatment override the parent/legal guardian's consent, or does the parent/legal guardian's consent override the minor's consent?	Neither the minor's nor the parent/legal guardian's consent invalidates the other. If either gives consent to mental health treatment, the minor can be treated under Act 147.

Appendix O (Continued)

Issue	Response
5. If both the minor aged 14-17 and the parent/legal guardian consent to treatment, does the parent/legal guardian still have the ability to release the minor's records as outlined in Act 147?	Act 147 states that when a parent or legal guardian has consented to treatment of a minor 14 years of age or older, the following applies to release of the minor's medical records and information: (1) The parent or legal guardian may consent to release of the minor's medical records and information, including records of prior mental health treatment for which the parent or legal guardian had provided consent, to the minor's current mental health treatment provider. (2) If deemed pertinent by the minor's current mental health treatment provider, the release of information may include a minor's mental health records and information from prior mental health treatment for which the minor had provided consent to treatment. (3) The parent or legal guardian may consent to the release of the minor's mental health records and information to the primary care provider if such release would not be detrimental to the minor. The act doesn't specifically address who controls release of the record when both the minor and parent consent to treatment. It is probably beneficial to try to determine this at the beginning of treatment so the issue of control over release of records is clear to all parties.
6. When a parent/legal guardian has the right to release a 14-to-17-year-old minor's mental health treatment records under Act 147, do they also have the right to access the records themselves?	No. Act 147 clearly states that when parents may consent to the release of a 14-to-17-year-old minor's records, the release is limited to release directly from one provider of mental health treatment to another or from the provider of mental health treatment to the primary care provider.
7. What information from a 14-to-17-year-old minor's mental health treatment records does a parent/legal guardian have access to?	Act 147 states that the parent or legal guardian who is providing consent to mental health treatment of a minor 14 years of age or older has the right to information necessary for providing consent to the minor's mental health treatment including symptoms and conditions to be treated, medications and other treatments to be provided, risks and benefits, and expected results.
8. What are the country reporting requirements regarding Act 147?	The act does not require any state agencies to monitor the implementation of the act or to collect information regarding the act; however, counties are advised to maintain sufficient records of the number of petitions filed under section 1.1 (B)(7) and (8) of the act, including an assessment of those petitions resulting in treatment or continued treatment and the ordered treatment period, in order to respond to the survey from the Legislative Budget and Finance Committee referenced in Section 2 of the act.

Appendix O (Continued)

Issue	Response
9. Can a 14-17 year old consent to medication as a treatment in the outpatient setting without the parent/legal guardian being informed?	Yes, medication prescribed for mental health treatment is considered to fall under the definition of mental health treatment. As in all treatment decisions, clinical judgment should be exercised.
10. Can a 14-17 year old consent to medication as a treatment in the inpatient setting without the parent/legal guardian being informed?	Yes, medication prescribed for mental health treatment is considered to fall under the definition of mental health treatment. As in all treatment decisions, clinical judgment should be exercised.
11. Is there any stipulation or mechanism that will inform the parent or youth when the other has signed release of records or right/denial of treatment?	There is no stipulation in the act; providers may want to consider addressing this issue in consent and release of information forms.
12. Is there a specified time frame for the facility to file a petition when a minor aged 14-17 objects to inpatient treatment consented to by a parent/legal guardian?	The act does not give a time frame; OMHSAS' position is that the petition should be filed as soon as is reasonably possible.
13. If a minor aged 14-17 objects to inpatient treatment consented to by a parent/legal guardian, does the minor remain in the facility until the outcome of the court decision?	Yes, a minor who has been confined for inpatient treatment on the consent of a parent/legal guardian and who objects to continued inpatient treatment may file a petition requesting a withdrawal from or modification of treatment.
14. Is a CRR host home considered inpatient or outpatient under Act 147?	A CRR host home is considered to be outpatient treatment.
15. The county's ability to monitor treatment is limited when minors go out of the county for inpatient treatment, since the county where treatment is occurring handles any petitions filed when minors object to treatment.	This is an implementation issue that should be addressed among counties.
16. Who is responsible for the attorney and court costs when a minor aged 14-17 objects to inpatient treatment and a petition is filed with the court?	The Department has no authority to make this determination.
17. Who should be contacted in the court system when a minor aged 14-17 objects to inpatient treatment and a petition is filed?	This is an implementation that must be addressed in each individual county.

Appendix O (Continued)

Issue	Response
18. How does Act 147 apply to minors aged 14-17 who are from another state and placed in inpatient PA settings?	Act 147 applies to all minors aged 14-17 receiving mental health treatment in Pennsylvania.
19. How does Act 147 apply to minors aged 14-17 who are from PA and are receiving mental health treatment in another state?	Act 147 applies to all minors aged 14-17 receiving mental health treatment in Pennsylvania.
20. How will minors aged 14-17 be transported to an inpatient facility when they disagree with treatment, don't meet involuntary criteria, and the parent/legal guardian consents to inpatient treatment?	They would be transported the same way children under age 14 are transported when a parent consents to inpatient treatment and the child doesn't meet involuntary commitment criteria.
21. May a parent/legal guardian consent to inpatient treatment for a minor aged 14-17 based on the recommendation of any physician who has examined the minor, or does the physician have to be a psychiatrist?	Act 147 states that a parent/legal guardian can consent to inpatient treatment for a minor aged 14-17 based on the recommendation of a physician who has examined the minor. This language is consistent with the Mental Health Procedures Act language regarding involuntary commitment decisions.
22. In cases where a parent/legal guardian consents to inpatient or outpatient treatment for their minor aged 14-17, and the minor resists treatment, is it appropriate to contact law enforcement to transport the minor to treatment?	Act 147 does not address the use of law enforcement or a "peace officer" as addressed in the Mental Health Procedures Act regarding involuntary commitments.
23. In cases where a parent/legal guardian consents to inpatient or outpatient treatment for their minor aged 14-17, and the minor resists treatment, is it appropriate to engage in the use of restraints to detain the minor for treatment?	No. OMHSAS Bulletin 02-01 issued 4/8/02 addresses the use of seclusion and restraint in mental health facilities and programs.

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*Link to Senate Bill 137: http://www2.legis.state.pa.us/WU01/LI/BI/BT/2003/0/SB0137P1921.pdf

Source: OMHSAS.

APPENDIX P

Response to This Report

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

Estelle B. Richman
Secretary

Telephone 717-787-2600/3600
FAX 717-772-2062

JUN 15 2006

Mr. Philip Durgin
Executive Director
Legislative Budget and Finance Committee
Room 400A Finance Building
Harrisburg, Pennsylvania 17105

Dear Mr. Durgin:

Thank you for the opportunity to review a draft of the report, *Pennsylvania's Mental Health System for Children and Youth.* This letter was prepared by the Department of Public Welfare (DPW), Pennsylvania Department of Education (PDE), and the Governor's Office, and as such is the Administration's response to the draft report that you shared with each agency. We appreciate the opportunity to respond in advance of the report's dissemination.

The Rendell Administration strives to address children's mental health issues using a coordinated approach that recognizes that children's needs often transcend program or even departmental boundaries. Your report demonstrates that there is a clear need for more efficient delivery of highly effective services for Pennsylvania's children. We value the extensive work performed by you and your staff in representing both Pennsylvania's promising accomplishments, and the areas in need of progress and innovation.

We have reviewed your findings and your recommendations. In response, we offer comments on selected recommendations.

Recommendation One: The Commonwealth should develop a strategic plan and prioritize objectives for improving mental health services to children and youth.

We agree that good planning is critical and note that several strategic planning processes involving internal and external stakeholders and families are already underway. The Department of Public Welfare, in cooperation with PDE and the Department of Health, began a major state-local planning effort three years ago with the Integrated Children's Services Plans. One of the objectives of this process is to tackle the need for better coordination among the different child serving agencies by requiring an integrated planning process for children's services. Failure of the different systems to work together will diminish the ability to provide mental health services to children who are involved with multiple systems. Building on the momentum of the Integrated Children's Services Planning process is an efficient and effective way to begin to address the gaps and complexities in the children's behavioral health systems.

Interagency coordination is essential to successfully delivering mental health services to children in whatever setting they are found. We strongly agree that interagency initiatives of this nature remove barriers between multiple systems, thus permitting students to receive mental health services more efficiently. This cross-agency cooperation is presently occurring in an unprecedented manner in many areas such as the interagency work group for Student Assistance, the School Based Behavioral Health Initiative and the pilot project for preschoolers with Autism in the southeast portion of the Commonwealth. PDE and DPW find the recommendation that the Administration create a Children's Mental Health Services Coordinator interesting, and we would be willing to give it further consideration and study. Operating in a multi-agency environment is challenging under any circumstances and it is important that if such a position were to be created that it had the necessary supports to succeed on this important mission.

You recommend that steps should be taken to promote greater involvement by school districts in meeting the needs of children with mental and behavioral health problems. The primary mission of local school districts is the education of its students. The role of schools is not the provision of mental health services, but rather to ensure that mental health services, when needed, are delivered efficiently and effectively to children and youth by those experts qualified to do so. As evidenced by the recent PDE/DPW School Based Behavioral Health Initiative and forums held this spring, as well as the other interagency initiatives highlighted in the report, we recognize that schools and mental health delivery systems must work in strong partnership. In December, the State Board of Education adopted regulations in 22 Pa. Code, Chapter 12, which require every school district to include a student services plan as part of its strategic plan and to offer a student assistance program in all grades. Student assistance programs seek to identify barriers to learning and also serve as a referral to available mental health services. PDE is also conducting a third party evaluation of alternative education programs and outcomes, while working more closely with school counselors, pupil services administrators, special education staff and community and professional organizations. PDE is integrating these issues with high school reform and early childhood initiatives. We strongly promote evidence-based programs, as we also do in our academic efforts, and we believe that prevention must be a major emphasis in our work, as well as ongoing and high quality professional development and technical assistance. PDE and DPW will continue to explore the funding of collaborative programs and other innovative approaches, such as instituting co-located services, to ensure that mental health delivery systems may access children and youth when students require those services.

The report, however, refers to a perceived lack of emotional support programs in school districts. Local school boards, not PDE, establish the education programs in all 501 school districts in the Commonwealth. Furthermore, these local school districts have a legal obligation to offer education programs that provide a free appropriate public education to students eligible to receive special education as required by the Individuals with Disabilities Education Act (IDEA) and governing state law. Where the individualized education program of a child with a disability requires emotional support services, they must be provided. In the event that a parent perceives that a child is not receiving the services to which they are entitled, the IDEA and state special education regulations provide a variety of mechanisms to secure such services from a school district.

Recommendation Two: The Department of Public Welfare should take steps to further encourage evidence-based programs and services.

We support your recommendation that DPW should advance evidence-based practices in all of its child-serving programs. In the northeast part of the state, a SAMHSA-funded "Science to Service" Initiative is underway. The initiative seeks to discover and highlight not just evidence-based practices, but also culturally appropriate and promising/emerging practices. PDE, in concert with DPW and the CASSP Institute, (DPW's training entity), hosted the inaugural School-Based Behavioral Health Conference this spring. This event marks one method that we can begin jointly to build a foundation of best practices for children's mental health across the continuum.

Evidence indicates that early identification of mental health problems and swift intervention is critical for children. The Commonwealth's early childhood programs in the Western part of the state are involved in a Heinz Foundation-funded pilot Pennsylvania to provide direct consultation services to early learning programs and to work on developing a systemic approach to infant-toddler services more generally. Concurrently under development in DPW is the identification of service provision models and funding requirements to initiate a state-administered mental health consultation program for early learning programs.

The report also reviews the use of Therapeutic Staff Support (TSS) and recommends that DPW conduct a pilot evaluation study to assess the effectiveness of TSS services. DPW is aware of the evidence suggesting that TSS may be over prescribed and has been encouraging local efforts to provide innovative alternatives to traditional TSS and other service models for children in need of mental health supports, in school settings and elsewhere, some of which are described in the report. The Department expects that the recommendations of both the Autism Task Force and the Children's Behavioral Health Task Force will assist in those efforts.

The Administration's primary commitment remains serving each child in a way that is clinically appropriate and addresses the individual needs of the child. DPW will continue seek evidence from the field on appropriate utilization practices and continue to explore alternatives to TSS to meet that commitment.

The report asserts that the current education system does not meet the needs of people living with autism. To the contrary, the current education system is working harder than ever to meet this dramatically increasing need. School districts and preschool programs are serving 443.7% more children with autism than they did ten years ago. Department of Education data indicate there were 1593 children (ages 3-21) identified with autism in 1995/96, while there were 8661 students identified in 2004/05. Nationally, it has been determined that 1 in 166 individuals live with some form of autism (or technically are on the autism spectrum). The Department of Education has supported the development of new programs to meet the needs of students with Autism Spectrum Disorder. Training for school staff has also been a priority. The Department of Education, in collaboration with DPW and with stakeholder input, has developed a plan for cross-agency training and professional development, and for an integrated approach to assessment. DPW's Director of Autism Affairs meets regularly with the Director of the PDE Bureau of Special Education to coordinate activities and to develop strategies for collaboration by service providers that will address coordinated service plans. This level of coordination and collaboration between PDE and DPW is unprecedented and we support its continuation. Despite efforts at coordination, however, it must be noted that the provision of education services in Pennsylvania is the primary responsibility of 501 local school districts, so it is inevitable that some variation exists in the programs offered by the various districts. Regardless, state and federal special education laws require that all school districts provide a free appropriate public education to individuals with disabilities and offer a variety of mechanisms to assure that this is accomplished.

Recommendation Six: The General Assembly should consider amending the Juvenile Act to address concerns about self-incrimination when using MH screening and assessment instruments.

We strongly support this recommendation. It would be in the best interest of the child to assure there are no barriers in place for children to receive services that they desperately need.

Recommendation Seven: The General Assembly should consider amending existing statutes on confidentiality requirements if it is determined that these changes cannot occur through amendments to regulation.

We strongly support this recommendation, which echoes your 2003 report, *Drug and Alcohol Treatment Services in a Managed Care Environment*. The Governor's Policy Office has made this issue a priority by dedicating staff to coordinate system changes to enable more efficient and seamless drug and alcohol and mental health treatment services.

Although we chose to comment only on selected recommendations, we look forward to further examination, evaluation, and discussion of all of them. This report has afforded us the chance to look at the system as a whole, and to consider both short and long term policy and programmatic priorities. On behalf of some of Pennsylvania's most vulnerable young people, thank you for your work to help improve the children's mental health system.

Sincerely,

Estelle B. Richman

Estelle B. Richman
Secretary of Public Welfare

Gerald L. Zahorchak

Gerald L. Zahorchak, D.Ed.
Secretary of Education