

# ***ACTION ALLIANCE***

## *For Children's Behavioral Health*

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PROVIDING BEHAVIORAL HEALTH CARE SERVICES TO  
CHILDREN AND ADOLESCENTS IN PENNSYLVANIA

A PLAN FOR ACTION AND REFORM

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## PREFACE

All children and adolescents face complex challenges in today's world. For some, getting through each day is complicated by mental illness, severe emotional disturbances and/or disabilities that may result in behavioral challenges.

In this document, we present our vision of how help can be brought to these children\* and their families in the most effective and cost efficient manner possible. We urge a re-focus of all service providing systems – away from costly long-term one-on-one services or residential placements to providing evidenced based services early, consistently, collaboratively, and in the most integrated environment appropriate for the child and family.

The 2003 Report by the President's New Freedom Commission on Mental Health urged the development of cross-system "Comprehensive State Mental Health Plans."

*"To be effective, the plan must reach beyond the traditional State mental health agency and the block grant to address the full range of treatment and support service programs that mental health consumers and their families should have. The planning process should support a respectful, collaborative dialogue among stakeholders, resulting in an extensive coordinated State system of services and support." (Report at p.33)*

In our vision, the majority of services must be provided in the home, school and community.

- ◆ **IN THE HOME.** We urge that a wide range of services be provided as prescribed to children and families in their homes. We also include Home-Based Crisis Stabilization, to provide intensive crisis intervention in the home to help avoid the need for hospitalization, police or juvenile justice intervention, or other out of home referrals. The establishment of community or home-based therapeutic care is also essential.
- ◆ **IN THE SCHOOL.** Again, a collaborative, local process is proposed. Education is a key partner in the model. The President's Commission found that a full **50%** of students with mental and or behavioral health needs drop out of school.

*"Schools are where children spend most of each day. While schools are primarily concerned with education, mental health is essential to learning as well as to social and emotional development. Because of this important interplay between emotional health and school success,*

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\* The words "child," "children," "youngsters," "adolescents," and "youth" are used interchangeably throughout this document.

*schools must be partners in the mental health care of our children.”*  
(Report at p. 58)

- ◆ **IN THE COMMUNITY.** We propose an expansion of services in community settings, including the availability of Site-Based Therapeutic Stabilization from one to ten days at small community settings that offer a home-like, comfortable atmosphere and the provision of assessment, medication monitoring, child and family therapy and training.
- ◆ **RESIDENTIAL SERVICES.** With expanded resources in schools and at home, we believe there will be a reduction in costly long-term partial hospitalization and RTF programs. However, we acknowledge that placement in RTFs may still be needed by some youngsters. These placements should be as close to home as possible and be committed to moving towards a restraint free environment. We do allow for after-school partials on an on-going basis. We also acknowledge that this section must be supplemented by protocols on entry, identifying effective treatment, measurement of progress, length of stay, full educational opportunities and discharge planning.
- ◆ **FAMILY SERVICES.** Peer advocates must be available across the state to assist families to obtain needed services for their children across all child-serving systems. Parents and youth must be included in the design, governance and evaluation of all services for children.

The *Action Alliance* is an *ad hoc* group of parents and children’s advocates, all with extensive experiences with the mental and behavioral health care system, the public education system, CYS, and juvenile justice. We are aware that other task forces and groups are involved in similar efforts. We applaud those efforts and do not see ourselves in conflict with them. We hope that this document will assist and not hinder the task force process.

Will there be costs involved? Yes, to some extent. But there are also substantial costs to be saved by improving service delivery. As recently found by Pennsylvania State University researchers, by providing effective, efficient mental and behavioral services, significant savings will occur in other child-serving systems. E. Michael Foster, lead professor in the research study, was quoted in the Penn State press release as saying:

“Mental health services that keep youth out of the juvenile justice system, for example, not only save tax dollars that would have to be spent on that sector but also reduce the suffering of youth and their families.”

(See, Foster and Conner, *Psychiatric Services*, 56:50-55, American Psychiatric Association, January 2005.) That study did not even take account of the administrative costs to be saved by the various child-serving systems, including Education.

Is there more work to be done? Absolutely. What we are offering is a vision of what the system should provide, not the steps it will take to get there. For example, much work needs to be done to develop the necessary funding mechanisms, such as blended or braided funding. Also, there are sections that we believed beyond our sole expertise and require collaboration with mental health professional, providers and others; for example, the development and implementation protocols and the development of professional standards for evaluation, and identification of services and treatment needs.

Most importantly, we believe our plan will improve outcomes for children, and provide families the support they need, effectively and efficiently. It will encourage parent and youth involvement in all aspects of system design, governance and evaluation, and further assist parents and youngsters to advocate for themselves. The plan must be viewed as a “whole”; in that we cannot reduce expensive residential, partial hospital, or one-on-one services until appropriate collaborative programs exist in local schools, and home and community services are in place.

We hope that you will give it careful and thoughtful consideration. We welcome the opportunity to work with all constituents as we strive for these goals.

*Action Alliance for Children's Behavioral Health*

*June 1, 2005*

## A. GOAL OF BEHAVIORAL HEALTH SERVICES

To enable children to be healthy, successful and productive members of their families, schools and communities.

## B. GUIDING PRINCIPLES:

All behavioral health care services<sup>†</sup> shall adhere to the following principles:

1. Children and families shall be treated at all times with dignity and respect.
2. Services shall be child-centered and based on each child's individual needs. Adolescents or young adults who are or have been consumers of behavioral health services shall be part of the behavioral health planning process at all levels. Youngsters shall be provided information and training to encourage development of self-advocacy skills.
3. Services shall be family focused, recognizing that the child remains with the family long after treatment services end. Sensitivity to the family group, supporting the spirit of the family unit, and working within the existing family structure are necessary to minimize the stressors on the child and family.
4. Services shall be provided collaboratively with other child serving systems, including the Education system, whenever possible so long as confidentiality rights are protected.
5. Services shall be culturally competent.
6. Services to each child shall be provided in the language or mode of communication used by the youngster.
7. Services, including notices, meetings and plans that involve a child's parent<sup>‡</sup> shall be available in the language or mode of communication used by the parent and shall be scheduled and held at a time and place convenient for the parent.

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<sup>†</sup> The term "behavioral health care services" and "behavioral challenges" includes services to children with mental illness, severe emotional disturbances, or other disabilities that result in the need for services.

8. Counties must ensure that all types of services on the continuum of care are available and accessible to children with co-occurring physical, sensory, cognitive, neurological, health and other disabilities. This requires, among other things, architectural accessibility and accessible modes of communication.
9. Similar types, levels and quality of evaluations and therapeutic and behavioral services must be available with reasonable promptness in all counties of the Commonwealth, regardless of a county's managed care or fee-for-service status.
10. All services provided shall be consistent with best practices. Behavioral health services and treatment must be based on positive, rather than negative, approaches. Services should reflect the child's strengths and not be punitive in nature.
11. Services shall be provided in the least restrictive, most integrated setting appropriate for the child.
12. Parents, youth and young adult consumers<sup>§</sup> must be integral to the systemic planning, implementation and evaluation processes at the state and local level. This should include parent, youth and other consumer participation on planning committees and may also include surveys, focus groups, random phone calls, advisory meetings, etc.
13. The use of restraints must be recognized, not as treatment, but as treatment failure. Every program and residential facility responsible for the care or treatment of children with behavioral needs shall, to the extent consistent with best practices, implement a restraint free environment.
14. Parents must be given a choice of providers.

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<sup>‡</sup> The words "parent" and "parents" for the purpose of this document shall refer to the parent, legal guardian, kinship or other adult custodian such as a grandparent or other caretaker.

<sup>§</sup> As used in this document, the word "consumer" shall mean an individual who currently receives, or in the past has received, behavioral health care services.

15. Quality assurance and accountability, including outcome measures, must be developed with input from parents and youth consumers and shall be infused throughout the system.
16. Parents, families and children must be provided access to information, supports and strategies that ensure their meaningful participation in the design, implementation and monitoring of the child's services. Parents and children must be able to disagree with and request a change of treatment plans and/or clinicians and other staff when they are dissatisfied with the child's program or treatment, without retaliation. If a disagreement exists among members of the treatment team, parents and children shall be provided written information on their appeal rights.
17. While medication is often an appropriate treatment for behavioral conditions, other services requested by parents or youngsters should never be denied because the parents object to giving medication to their child, or a particular medication, or because of such objection by the youngster.
18. Parents and children have the right to have their records kept confidential as provided by Education, Mental Health and other applicable laws.
19. Children age 14 years and older may self-identify their need and participation in behavioral health care services. When therapeutically appropriate, such children shall be encouraged to discuss their services with their families.
20. Parents shall never be required to relinquish custody of their child for the sole purpose of receiving behavioral health care services.

#### C. EVALUATIONS FOR ELIGIBILITY FOR BEHAVIORAL HEALTH CARE SERVICES

1. Parents must have a choice of a least two evaluators who have the expertise to conduct a comprehensive evaluation of their child and who are independent of service providers. Mechanisms should be in place to ensure that evaluations

are free from “conflicts of interest.” There should be evaluation centers staffed by mental health professional evaluators who have access to expertise in rare and difficult diagnoses. With written parental permission, comprehensive evaluations should include a review of all previous evaluations and history, and information from all systems, including schools, that have served the youngster, and if indicated, should include psychiatric and multidisciplinary assessments and recommendations for services, if needed. Recommendations should be driven by the child’s needs and not by available resources or administrative convenience. If the parents do not wish to use the evaluation center, or are not satisfied with the evaluation, the system should pay for an independent evaluation by an MA enrolled professional of the parents’ choosing.

2. Eliminate unnecessary, redundant, evaluations, thus substantially reducing cost. Initial evaluations should be comprehensive, as described above. Re-evaluations for continuation of authorizations for most services (exclusive of inpatient, residential and partial hospital) should only be required every 6 months rather than 4 months; except evaluations for children who have autism spectrum disorders, traumatic brain injury, or other long-term, chronic behavioral needs, which should only be required once every year. Parents or provider may request and receive a more frequent full or partial evaluation at any time.

#### D. BEHAVIORAL HEALTH SERVICES AVAILABLE TO CHILDREN AND THEIR FAMILIES

##### 1. Services at home:

A. Availability of home-based intensive treatment on regularly scheduled, hourly, or daily basis as prescribed to include:

1. Direct psychological therapy to the child



2. Family Therapy (mobile and office)
3. Family-Based Services (in-home, and may include therapeutic crisis stabilization, family therapy, sibling support, for example.)
4. Behavioral Specialist
5. One-to-One Behavioral Supports when less intensive service have been tried but failed.
6. Mobile Therapy
7. Autism Support Aides.
8. Sibling Support Services.
9. Intensive Case Management.
10. Parent, family and youth education.
11. Family-Driven Funds.
12. Parent to parent Support.
13. Youth leadership and advocacy training and opportunities for peer support groups.
14. Home-Based Crisis Stabilization: the availability of crisis intervention teams to come to the child's home 24/7 when requested to stabilize the child and avoid the need for hospitalization, police/juvenile justice intervention, or other out-of-home placement or referral.
15. Community or Home-Based therapeutic care service: Short-term home or site-based therapeutic care services away from the family offered in a service plan, either as needed (e.g., when the child's aggressive or oppositional behavior could be alleviated by a short "cooling down" period away from the family), or on a regular schedule (e.g., every Saturday morning because that seems to be a particularly stressful time). This is not to be used as a substitute for careful reassessment and adjustment of treatment plans.

16. Therapeutic Foster Homes, with foster parents who have received, and continue to receive, extensive training in behavioral health care. All such placements shall be reviewed and monitored on at least a monthly basis, or more often if concerns exist.

2. Services at school:

A. A "Collaboration Team," consisting of parents; youth and young adult consumers, provider representatives; LEA representatives; regional/county MH representatives, and others as deemed appropriate by a Team member (hereinafter "Collaboration Team") should meet to determine the type of standing, collaborative MH/education school based programs suitable for the number and type of population of youngsters with behavioral needs and those at risk in the local community. Parents, family members, youth and young adult consumers and their chosen advocates shall compose at least 30% of the members of the Collaboration Team. Each district's Collaboration Team may develop locally based models of collaborative programs for children with behavioral needs, but must at a minimum provide in some fashion for:

1. Prevention services – to promote the mental health of all children and to promote understanding and sensitivity by all students towards those experiencing mental illness, emotional distress or behavioral challenges.
2. Availability of one-time, short-term, and regularly scheduled school-based therapeutic counseling as needed by children who self identify, or are referred by parents, school personnel or case managers.
3. Some array of therapeutic activities such as group therapy; peer support; anger management classes; drama, art or music therapy; and appropriate social skills training as needed by children who self identify, or are referred by parents, school personnel or case managers.
4. Therapeutic crisis intervention teams available within one or more schools composed of professional therapeutic intervention teams to respond to

immediate treatment needs of individual students to avoid unnecessary school discipline or referrals to police or hospitals.

5. Consultative services from mental health professionals to teachers, administrators and paraprofessionals regarding individual student needs.
  6. Training of school staff by parents, youth and young adult consumers, and mental health professionals, including behavior specialists, on understanding, preventing, recognizing, and dealing with treatment and significant behavioral challenges.\*\*
  7. Services from behavioral aides (including but not limited to autism support aides) to enable children to participate successfully in the least restrictive, most integrated classrooms appropriate for them. Services of behavioral aides should be provided on a shared basis whenever possible, and on an individual basis only when necessary.
  8. Therapeutic classrooms within a typical school designed by the Collaboration Team – provision of in-class treatment and education services from a highly qualified, certified teacher and one or more mental health professionals - when this is the least restrictive and most integrated service appropriate to the child's needs. This envisions a level of service considerably above that of an Emotional Support Class.
- B. All of the above listed services, with the exception of therapeutic classrooms and behavioral aides, should be available to all students without a need for a mental health diagnosis or a special education label, and without the need for funding authorization meetings or procedures.
- C. Chosen collaborative model(s), their descriptions and annual evaluation reports should appear in each school district's Special Education Plan, and each county's Children's Integrated Plan, to be approved by the appropriate Secretary or Secretary's designee.

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\*\* We strongly encourage participation of Drug and Alcohol representatives and the development of appropriate drug and alcohol service in conjunction with this effort, but the details of those services are beyond the scope of this Plan.

- D. Once a collaborative model is developed and implemented, each Collaboration Team shall meet at least quarterly to review anecdotal and other data regarding the program, and shall make whatever adjustments to the program, if any, are necessary.
- E. Blended or braided funding streams will be necessary to ensure availability of services to all students regardless of MA status and to avoid any unnecessary labeling of students. Collaboration and coordination with on-going programs, such as the SAP system in schools, alternative education and suicide prevention programs, and insurance should be maximized. Education dollars from IDEA (including early intervening funds) and other federal programs, including school improvement and Title I; NCLB; and state regular education dollars; dollars from Juvenile Justice and the Office of Child, Youth and Families should also be used.
- F. With respect to therapeutic classrooms and behavioral aides, there remain questions of which entity, school or MA, is making which decisions and when, and which system's due process procedures apply. In addition, if the model ties one MA provider to a school (which can be very beneficial), parents must have access to other providers if they are dissatisfied.

### 3. Community Based Services

- A. Each county should have an array of community based services that includes at least the following:
  - 1. Traditional inpatient, outpatient therapy and psychiatric visits, with access to providers who have appropriate expertise in the child's condition.
  - 2. Case management assistance (in person when necessary) in accessing all types of services and supports including, therapeutic, behavioral, educational, vocational, recreational, volunteer opportunities, etc.

3. County funds for participation in non-MA community programs, activities, sports and classes, etc. when the activities would have therapeutic value for the child and the family cannot afford them.
4. After school and weekend therapeutic programs that provide such things as:
  - a. Therapy and coping skills
  - b. Anger management / alternative resolution training
  - c. Social skills and life skills training
  - d. Intergenerational relationship building
  - e. Recreational and artistic therapies (e.g., drama therapy, photography, art therapy, etc...)
  - f. Therapeutic programs for children that promote self-awareness, self-advocacy and youth leadership skills
5. Individual or shared therapeutic aides if necessary for children to participate successfully with typical peers in inclusive recreational or other community activities, such as summer camp, extra-curricular sports and activities offered by the school, or community organizations such as the YM/WCA or YM/WHA; Scouts and PAL.
6. Mentoring/modeling/peer support programs, both youngster-to-youngster and adult to youngster, including mentoring of youngsters by adult consumers.\*
7. Drop in Centers for teens located in Malls or other similar areas easily accessible to youngsters, open 7 days/wk, with a Mental Health professional and other staff present at all times to provide needed therapeutic intervention on an individual or group basis. The Center should provide comfortable seating areas for youngsters to talk among themselves, watch TV, or listen to music to help them de-escalate and process therapeutic issues.\*

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\* All children may participate in these services without a mental health or special education label, and without the need for funding authorization meetings or procedures.

8. Teen Hotline (extension of suicide hot line) available 24/7/365.\*

*(Above services need to be available for extended hours and Saturdays to accommodate the child's school and families working schedules and their respective transportation needs.)*

9. Summer therapeutic programs.

10. After school partial hospitalization programs for children in need of continued, on-going therapeutic support.

11. Transitional programs for older adolescents such as:

a. Independent living programs and skill training

b. Transitional/vocational counselors

c. Job training/coaching

d. Preparation for further academic training, such as preparation for SAT or other examinations needed for educational or vocational degrees

e. Leadership and self-advocacy skills

12. Site-Based Therapeutic Stabilization, as an additional alternative to hospitalization, juvenile justice, child welfare or other out of home referral: One to ten day 24 hour crisis stabilization for children in a small, community setting that offers a home-like, comfortable, and private atmosphere. Services offered to include such things as: assessment; medication monitoring; individual, group, and family therapy; social and coping skills; education (preferably in child's regular school); family training on recognition, interventions and de-escalation techniques; and discharge service coordination.

13. Acute Partial Hospital Programs (PHPs) designed to be short-term stabilization programs. PHPs shall have the goal of returning the child to the home school environment as quickly as medically possible. Children in PHPs shall receive daily individual and group therapy. PHPs are not educational placements. Except for extraordinary circumstances, no child

shall remain in a PHP for more than three school weeks. Protocols regarding entry, exceptions to the length of stay, coordination of educational services with the child's home school district, and discharge planning will need to be developed.

14. Peer Families Advocacy Projects to support families in accessing the skills and information needed to care for their children in conformance with evidence based and promising practices. (This service serves as an alternate means to provide some of the functions that case workers have traditionally tried to address. Caseworkers should partner with families to manage services, and peer advocates should be available to support the families and consumers in negotiating the systems. This eliminates conflicts of interests, and offers the families and children an ombudsman who can support their interests without deference to agency or government politics).

#### 4. Residential Services (TO BE EXPANDED)

- A. It is hoped that the provision of a greater array of home, school and community based services will result in fewer children needing residential treatment and shorter stays for those children in residential treatment. In some cases though, residential treatment may still be necessary.
- B. Residential placements should be as homelike and as close to home, community and school as possible. Residents shall be provided weekly psychiatric visits and both individual and group therapy on a weekly basis.
- C. Since family involvement is critical to a child's reintegration into the family, children should not be placed more than 50 miles from their homes (and transportation and child-care should be available for family visits). To address a child's unique needs, placements at a distance in excess of 50 miles may be made with the written consent of the parents.
- D. Children should attend their local community schools whenever it is therapeutically appropriate to do so.

- E. For all of the above reasons, while traditional RTF's may have their place, each county should make available within its borders, small community-based residential placements such as group homes or community residential rehabilitation arrangements.
- F. Counties within a single region of the state should join together to ensure the availability of small specialized placements for those children whose specialized needs require it. (E.g., there should be sign language fluent residential programs available to children who communicate primarily by way of sign language; there should be programs that have expertise in serving children with behavioral needs and mental retardation or autism.)
- G. Additional protocols must be developed with relevant constituencies providing for:
  - 1. Criteria and procedure for admissions to RTFs
  - 2. Length of stay
  - 3. Development of individual treatment plans with measurable outcomes
  - 4. Development of individualized behavior plans rather than a "one size fits all" behavioral system
  - 5. Regularly scheduled outcome monitoring
  - 6. Provision of education program
  - 7. Advanced discharge planning and coordination with school, next placement and community.
  - 8. Meaningful inclusion of parents and youth at all meetings and outcome monitorings; and on-going communication with parents.



## 5. USE OF RESTRAINTS

*[Paragraphs A through C below are a brief summary of an article by Gordon R. Hodas, MD, the Statewide Child and Adolescent Psychiatric Consultant for Pennsylvania's Office of Mental Health and Substance Abuse Services. Published in Residential Care Quarterly, Winter 2004, it is reprinted with the permission of Dr. Hodas.]*

- A. Restraint and seclusion are therapeutic failures. The claim that restraint and seclusion are considered therapeutic interventions reflects lack of appreciation of the distinction between a therapeutic intervention and an emergency intervention performed in the name of safety. Therapeutic interventions include staff relationship-building, developing trusting staff-therapeutic alliances, supporting the child's competence, promoting the child's social skills and problem solving, developing and implementing an individualized treatment plan, and collaborating with the child and family as partners.
- B. Obtaining essential clinical information, as provided by risk assessments, de-escalation preference surveys, and advanced directives, is an important component of a therapeutic intervention. Maintaining a welcoming, non-intimidating milieu and culture constitute a therapeutic intervention as well. Staff de-escalation of distressed children involves a set of essential therapeutic interventions.
- C. Agencies serving children with challenging behavior and significant psychiatric disturbance shall:
  - 1. Recognize that the issue involves both reducing restraint and seclusion and changing the way we work with children and their families. Restraint and seclusion represent treatment failure, not therapeutic interventions.
  - 2. Begin by making change at the top, with strong administrative and clinical leadership to change culture and practices.
  - 3. Consistent with primary prevention, make the milieu welcoming and flexible.

4. Use tools that engage the child and promote collaboration (for example, risk assessment and de-escalation preference tools), and be guided by a meaningful treatment plan.
  5. Train staff in relationship building (primary prevention) and a range of de-escalation methods (secondary prevention).
  6. In response to crisis, use available tools, knowledge, and therapeutic relationships to help the child stabilize and avoid the need for restraint or seclusion.
  7. When restraint or seclusion becomes necessary, implement either one safely and as briefly as possible. Consider treatment failure an opportunity for clinical learning and system improvement, so the future need for restraint and seclusion for that child—and for any child—becomes less likely.
- D. Each provider shall maintain a data based system logging each restraint incident, so that the use of restraints can be tracked by facility; date; time; staff involved; children involved; injury, if any; outcome; and next steps. Corresponding reports shall be generated by each facility and summary data as requested shall be submitted to the OMHSAS Children’s Bureau, Medical Unit, and OMHSAS Children’s Advisory Panel on monthly basis for analysis and determination of training needs and priorities. Parents shall be notified promptly by their provider of all incidents and of injury reports concerning their children, to the extent required by the Mental Health Procedures Act.

## 6. FAMILY

- A. Families must have access to locally based, autonomous family advocates to support their ability to access and use public service for their children. These advocates must:
1. Be peer advocates for families free from agency and governmental politics.

2. Have the capacity to assist families with their needs across all child-serving systems and natural and community supports.
  3. Be culturally competent and able to serve the diversity of Pennsylvania families.
  4. Have access to ongoing training and education from all relevant systems.
- B. All relevant systems need to support fiscally a state-wide system of independent, county-based advocates to assist families and youngsters in negotiating their way through the systems. System resources must be realigned to include funding for family/youth advocacy, education and systems work.

#### ADDITIONAL SECTIONS TO BE DONE:

*The Action Alliance believes that, at minimum, the following sections need to be developed. We also believe that to do so, input from other constituencies are needed, such as the CBHTF, other parent coalitions; adolescent and young adult consumers; OMHSAS-CB staff; Department of Education staff; medical and mental health professionals; providers and others. In addition, input from the Office of Child Development, the Office of Medical Assistance Programs, and the Office of Insurance Reform should be sought. We set out below just some of the questions and concerns that must be addressed.*

#### **Early Identification and intervention; child find activities**

Do we employ screenings, and if so, who administers the screening using what tool?

Using EPSDT; early intervention/head start programs.

Referrals by families, school personnel and MH system.

Outreach to community and to youngsters with treatment or behavioral needs concerning types of services available and how to access them.

Identification of symptoms/behaviors that would lead to comprehensive evaluation, such as poor attendance at school, continued failing grades; disciplinary or police involvement, on-going withdrawal, depression or suicidal thoughts, etc.

## **Training**

Training of staff towards restraint free environments (see curriculum of Gordon Hodas, MD for developing restraint free environments).

Development of on-going training and refresher courses for all mental, behavioral and educational staff and for families on understanding and applying best practices and principles.

Inclusion of parent, youth and young adult consumers, as presenters in training of school and mental/behavioral health staff.

Training, support, materials and organized advocacy for families and youngsters with behavioral challenges throughout the state.

## **Standards**

Development of professional standards for evaluation, and identification of services and treatment needs.

How do we define progress? And how do we measure it on a set schedule by teams, including the parent and youngster?

How to we develop measurable, meaningful outcomes, and monitor them on a regular basis?

There is a need to treat child care workers and Behavior Health staff as professionals; provide them with a career ladder and on-going training; decent pay and fringe benefits. Reimbursement for travel time, training and all systems' necessary meetings

## **Personnel Qualifications**

### **Funding, blended/braided funding, vouchers, waivers, etc**

### **Due Process**

Establishment of complaint process in Fee-For-Service, and establishment of a mediation process throughout the state

### **Authorization process**

## APPENDIX I

### **The President’s New Freedom Commission on Mental Health’s Goals and Objectives**

<b>Goal 1</b>	<b>Americans Understand that Mental Health Is Essential to Overall Health.</b>	
	Recommendations	<p>1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.</p> <p>1.2 Address mental health with the same urgency as physical health.</p>
<b>Goal 2</b>	<b>Mental Health Care Is Consumer and Family Driven.</b>	
	Recommendations	<p>2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.</p> <p>2.2 Involve consumers and families fully in orienting the mental health system toward recovery.</p> <p>2.3 Align relevant Federal programs to improve access and accountability for mental health services.</p> <p>2.4 Create a Comprehensive State Mental Health Plan.</p> <p>2.5 Protect and enhance the rights of people with mental illnesses.</p>
<b>Goal 3</b>	<b>Disparities in Mental Health Services Are Eliminated.</b>	
	Recommendations	<p>3.1 Improve access to quality care that is culturally competent.</p> <p>3.2 Improve access to quality care in rural and geographically remote areas.</p>
<b>Goal 4</b>	<b>Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.</b>	
	Recommendations	<p>4.1 Promote the mental health of young children.</p> <p>4.2 Improve and expand school mental health programs.</p> <p>4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.</p> <p>4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.</p>
<b>Goal 5</b>	<b>Excellent Mental Health Care Is Delivered and Research Is Accelerated.</b>	
	Recommendations	<p>5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.</p> <p>5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.</p> <p>5.3 Improve and expand the workforce providing evidence-based mental health services and supports.</p>

		5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.
<b>Goal 6</b>	<b>Technology Is Used to Access Mental Health Care and Information.</b>	
	Recommendations	<p>6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.</p> <p>6.2 Develop and implement integrated electronic health record and personal health information systems.</p>

## APPENDIX II

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Linda Rainey, parent, advocate (Erie County)  
Luz Hernandez, parent, advocate (Philadelphia County)  
Mary Ann Donovan, parent, advocate (Bucks County)  
Mary Jane Yevic, parent, advocate (Lackawanna County)  
Rachel Mann, Esq., advocate (Philadelphia County)  
Sallie Lynagh, parent, advocate (Schuylkill County)  
Sherry Stark, parent, advocate (Bucks County)  
Wendy Luckenbill, parent, advocate (Berks County)