Mayor’s Youth Mental Health Commission
Needs Assessment Committee

Final Report

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Maria Bledsoe, Central Florida Cares Health System

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Staff:
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Heather Thomas, Orange County Mental Health & Homeless Issues Division
Objectives:
1. To identify the current and future needs for mental health services, the state of current prevention and early identification programs and the areas where meaningful information is lacking.
2. To identify the difference between organic issues of mental health and behavioral issues and the extent of those issues in Orange County.
3. To identify by relevant social demographic factors the incidence of various mental health issues.
4. To establish meaningful and measureable metrics to assess progress in both treatment and prevention.

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

Orange County Data
Population: Based on 2011 census data, Orange County has a population of 1,157,342 of which 273,753 are children under the age of 18. The number of children in Orange County is projected to rise to 369,414 by the year 2030, and the percent of children will remain relatively stable at 23.1% of the total population, (Kids County Data Center, 2011).
Funding: Florida is currently ranked 49th in the nation in funding for mental health services. Orange County and the central Florida region is the 2nd lowest funded in the state, despite having the fourth largest child population in Florida, (Kaiser Foundation, 2013). Additionally, 2011 data indicates there were 210,885 persons living in poverty in Orange County and 69,633 were under the age of 18. According to the 2013 PRC Child and Adolescent Community Health Needs Assessment sponsored by Nemours Children’s Hospital, 6.2% of families report having no coverage for their child’s healthcare expenses.

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

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

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

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

Organic vs. Behavioral – Through research and discussion the Needs Assessment Committee recognizes this is a complicated issue based on biology, environment, trauma and other stressors. There is not enough advancement in the field of psychiatry to ensure that the two can be separated. Additionally, behavioral problems may be an indicator for a long-term mental health
disorder. Because of these issues the types of behavioral symptomology that is present in a child/youth/young adult impacts the type of treatment to be provided and has no impact on whether to provide treatment or not. Every child/youth/young adult is entitled to a holistic treatment approach that requires understanding them in the context of their environment and in the context of their experiences.

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

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

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

**County-Wide Key Indicators (Scope of the Need)**

**Juvenile Justice Data**

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

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

**Arrests by Age**

<table>
<thead>
<tr>
<th>Orange County</th>
<th>2010-2011</th>
<th>2011-2012</th>
<th>2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-10 yrs</td>
<td>149</td>
<td>113</td>
<td>84</td>
</tr>
<tr>
<td>11-12 yrs</td>
<td>459</td>
<td>367</td>
<td>404</td>
</tr>
<tr>
<td>13-14 yrs</td>
<td>1,830</td>
<td>1,683</td>
<td>1,553</td>
</tr>
<tr>
<td>15 yrs</td>
<td>1,843</td>
<td>1,568</td>
<td>1,508</td>
</tr>
<tr>
<td>16 yrs</td>
<td>2,375</td>
<td>2,046</td>
<td>1,780</td>
</tr>
<tr>
<td>17+ yrs</td>
<td>3,159</td>
<td>2,628</td>
<td>2,191</td>
</tr>
</tbody>
</table>
Civil Citation

<table>
<thead>
<tr>
<th></th>
<th>2011-2012</th>
<th>2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of Florida</td>
<td>6,933</td>
<td>7,329</td>
</tr>
<tr>
<td>Orange County</td>
<td>8</td>
<td>93</td>
</tr>
</tbody>
</table>

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

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

An overview of the full PACT assessment from 2007 - 2012 indicated the following for juveniles in Orange County. Comparatively, these outcomes are very similar to the Statewide outcomes:
- 44% indicate a Mental Health Issue
- 26% indicate a Mental Health Diagnosis
- 4% report Suicide Attempts
- 27% report diagnosis of ADHD

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

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

<table>
<thead>
<tr>
<th>Number of Schools</th>
<th>Number of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elementary**</td>
<td>123</td>
</tr>
<tr>
<td>K-8</td>
<td>3</td>
</tr>
<tr>
<td>Middle</td>
<td>35</td>
</tr>
<tr>
<td>High</td>
<td>19</td>
</tr>
<tr>
<td>Exceptional</td>
<td>4</td>
</tr>
<tr>
<td>Alternative</td>
<td></td>
</tr>
<tr>
<td>Charter</td>
<td></td>
</tr>
<tr>
<td><strong>Total 184</strong></td>
<td><strong>187,193</strong></td>
</tr>
</tbody>
</table>

**Includes Pre-K *As of Oct. 15, 2013
Orange County Public School Disciplinary Action

<table>
<thead>
<tr>
<th>OCPS</th>
<th>2011-2012</th>
<th>2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspensions</td>
<td>27,446</td>
<td>28,517</td>
</tr>
<tr>
<td>Students Suspended</td>
<td>16,248</td>
<td>15,273</td>
</tr>
<tr>
<td>ESE Students Suspended</td>
<td>3,872</td>
<td>3,506</td>
</tr>
<tr>
<td>Expulsions</td>
<td>20</td>
<td>27</td>
</tr>
</tbody>
</table>

Orange County Public Schools Student Racial/Ethnic Distribution

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

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

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>African American</th>
<th>Hispanic</th>
<th>Asian/Pacific Islander</th>
<th>American Indian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspensions</td>
<td>16%</td>
<td>54%</td>
<td>29%</td>
<td>1%</td>
<td>.2%</td>
</tr>
<tr>
<td>Enrollment</td>
<td>34%</td>
<td>28%</td>
<td>33%</td>
<td>5%</td>
<td>.5%</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Black or African</th>
<th>Hispanic/Latino</th>
<th>Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>1.4%</td>
<td>1.8%</td>
<td>1.6%</td>
<td>3.0%</td>
</tr>
<tr>
<td>2009-10</td>
<td>1.2%</td>
<td>1.6%</td>
<td>1.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>2010-11</td>
<td>1.1%</td>
<td>1.6%</td>
<td>1.4%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

Orange County Public Schools overall dropout rates continue to improve to just under 2% in the 2010-2011 school year. Each student who drops out of high school costs our society $260,000 (Riley& Peterson, 2008) in lost earnings, taxes, and productivity (much more when you factor in
the extra financial and social costs of delinquency, prison, teenage parenting, and publicly funded entitlements such as Medicaid, food stamps, and Temporary Assistance for Needy Families).

**Early Identification – Orange County Public Schools**

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

<table>
<thead>
<tr>
<th>Pre Kindergarten Students</th>
<th>2011-2012</th>
<th>2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students Screened</td>
<td>1,348</td>
<td>1,388</td>
</tr>
<tr>
<td>Referred to outside services</td>
<td>50</td>
<td>40</td>
</tr>
</tbody>
</table>

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

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

**OCPS 2013 -2014 budget for salary (includes benefits)**

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

**Child Welfare - Prenatal**

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.
According to the 2013 PRC Child and Adolescent Community Health Needs Assessment between 2009 and 2011, 23% of Orange County pregnant mothers did not receive prenatal treatment in the first trimester. This number rose to 39.9% amongst teen pregnancies. Children birth to age five who have social and emotional problems early in life are more likely to experience later problems as well as to develop serious mental illnesses later in life.

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

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

Child Welfare Data

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

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

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

CBC of Central Florida Child Welfare Data, 2012-2013
- 1,148 children in child welfare are residing in out-of-home care. Downward trend from 1,339 last year.
- Performance measures for diversion are on target.
• Problem areas are children receiving permanency within 12 months of entering care (34.1%) and children receiving permanency after 12 months in care (40.4%). The entire state struggles with the same.
• Orange County is below other areas in the state for youth ages 19-22 with a diploma or GED at 46.9%.

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

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

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

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

Behavioral Health Data
Orange County Baker Acts by Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAMH Funded</td>
<td>Unable to obtain</td>
<td>Unable to obtain</td>
<td>341 (duplicated in other numbers)</td>
<td>182 (duplicated in other numbers)</td>
</tr>
<tr>
<td>University Behavioral Center (includes some Seminole County)</td>
<td>75</td>
<td>155</td>
<td>139</td>
<td>405</td>
</tr>
<tr>
<td>Lakeside Behavioral Healthcare (75% Managed Medicaid)</td>
<td>1147</td>
<td>1235</td>
<td>1121</td>
<td>1277</td>
</tr>
<tr>
<td>Central Florida Behavioral</td>
<td>Not Provided</td>
<td>Not Provided</td>
<td>Not Provided</td>
<td>601</td>
</tr>
<tr>
<td>Total</td>
<td>1,222</td>
<td>1,390</td>
<td>1,260</td>
<td>2,283</td>
</tr>
</tbody>
</table>
2013 PRC Child and Adolescent Community Health Needs Assessment reports 7.1% of Orange County parents believe that their (age 5-17) child’s mental health is “fair” or “poor.” Parents reported that they were told by their child’s healthcare provider that 7.8% had anxiety and 4.8% had depression. Additionally, 8.7% of parents indicated their children (ages 5-17) felt sad or hopeless two or more weeks in the past year. Orange County responded unfavorably high compared to surrounding counties and national responses. Other areas of concern where Orange County responded higher include reports from families that their child worries a lot, has difficulty falling asleep, has made suicide attempts, and is on prescribed medication.

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

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

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

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

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

Children’s mental health services are disconnected from other child serving systems. The systems do not meet on a regular basis and do not develop cohesive plans that address the needs of the community. Our community designs programs based on available funding. Programs may or may not impact the overall health and wellness of children and families. These
communication breakdowns prevent children from being effectively identified, easily and effectively referred, and properly treated. The lack of overall system design discourages the critical role of collaboration with all child serving systems.

Results:

- Only 27% of children’s mental health needs are met in Florida
- Only 34% of adult’s mental health needs are met in Florida
- Only 15% of anyone’s substance abuse needs are met in Florida

***Obtained from the Department of Children and Families strategic plan, 2014-2016.

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

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

**Lack of consistent training**

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

**Not child centered**

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

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

2. **Inadequate funding, financing model disincentives and poor accountability**

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

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

- 30.5% of Orange County parents report some type of difficulty or delay in obtaining healthcare services for their child in the past year (PRC, 2013).
To complicate the complex manner in which services are funded, funding in Florida has focused on deep-end or crisis treatment rather than prevention of behavioral health and substance use disorders.

- Florida is 49th in the United States in the level of funding for behavioral health services at a mere $38.17 per capita. (Politifact).

- Mental Health funding is less than it was in the 1950’s (Florida Council for Community Mental Health, 2013).

- Community mental health system funding has remained flat with only a 3% increase in the last 5 years. During the same time period, adult mental health funding has declined 7.9% (Florida Council for Community Mental Health, 2013).

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

**Results:**

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

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

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

**Silos/units** - Mental health services in Orange County are delivered, almost completely, in “units”, one distinct service at a time. Often these individual services sit separately from any other services the child may be receiving. This delivery reality creates service “silos” that are uncoordinated and misinformed to meet the mental health needs of children.
**Requirements** - Each service provided comes with a unique set of requirements. Parents are frequently sent from one service provider to another as a result of these distinct qualifying requirements.

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

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

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

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

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

**Results:**
- Youth get passed from one system to another as problems get worse.
- Families relinquish custody to get help.
- Children are placed out of home.
**Lack of access** - With the lack of a clear entry point or clear eligibility, access becomes a challenge. Simple information and referral is ineffective, as families may end up with a list of providers for which they do not qualify. Providers are equally frustrated, wasting precious resources on qualification verifications and duplication of verifications.

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

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

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

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

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

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

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

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

Results:

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

6. **Lack of System Accountability**

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

Each child-serving system of care has a database and most utilize electronic records. Across the community in general there have not been any attempts to share information across systems to improve care offered to youth and families. Measureable outcomes are vital to improving systems and every agency and system has to agree to achieve transparency in data and outcome sharing.
Conclusions/Recommendations
The Needs Assessment Committee concludes that the current Youth Mental Health System for children/youth ages 0-24 is fragmented, uncoordinated, and woefully underfunded in comparison to national standards. Orange County data from all child-serving systems clearly support that our system is ineffective and does not meet the needs of children and families in our community. The body of research from around the nation is sufficient to provide Orange County with the information on the standards needed to create cost effective and lasting change in our County and allow us to attain better outcomes for children, youth and families. Therefore, the Needs Assessment Committee fully supports the recommendations from all of the other Committees under the Youth Mental Health Commission and in addition recommends the following:

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


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


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