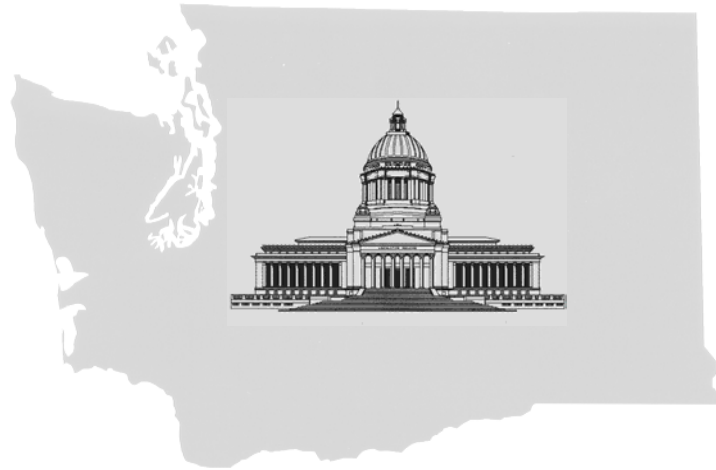


**State of Washington
Joint Legislative Audit and Review Committee (JLARC)**



Children's Mental Health Study

Report 02-5

August 7, 2002

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in alternative formats for persons with disabilities.*

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JLARC staff, under the direction of the Committee and the Legislative Auditor, conduct performance audits, program evaluations, sunset reviews and other policy and fiscal studies. These studies assess the efficiency and effectiveness of agency operations, impacts and outcomes of state programs, and levels of compliance with legislative direction and intent. The Committee makes recommendations to improve state government performance and to correct problems it identifies. The Committee also follows up on these recommendations to determine how they have been implemented. JLARC has, in recent years, received national recognition for a number of its major studies.

CHILDREN'S MENTAL HEALTH STUDY

REPORT 02-5

REPORT DIGEST

AUGUST 7, 2002



STATE OF WASHINGTON

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OVERVIEW

This JLARC study was mandated in the 2001-03 Biennial Budget. It reviews whether legislative intent has been fulfilled concerning the coordination of children's mental health planning and services and the implementation of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The study analyzes whether the 1991 children's mental health coordination statute provides appropriate direction for the Office of Financial Management (OFM) and the Department of Social and Health Services (DSHS) to carry out policy and management responsibilities. The availability and reliability of fiscal, program, outcome, and management data is also reviewed.

As a result of findings in these areas, this report makes five recommendations aimed at:

- Streamlining and better integrating programs and services; and
- Increasing the systematic collection, analysis, and reporting of children's mental health service outcomes and costs.

This study had a limited scope that did not include an evaluation of unmet needs for children's mental health services in Washington State.

BACKGROUND

Nationally, states' responsibilities for children's mental health care are dispersed across multiple child-serving systems: schools, primary health care, mental health systems, the juvenile justice system, child welfare, and substance abuse treatment. This pattern reflects the complicated nature of mental illness and the range of approaches to diagnosis and treatment. The 1991 Washington Legislature encouraged the development of community-based interagency collaborative efforts to plan for and provide mental health services for children. The Legislature intended to coordinate existing categorical children's mental health programs and funding, ensure sensitivity to unique cultural circumstances, eliminate duplicative case management and, to the greatest extent possible, blend categorical funding to offer more service options to each child. A framework for these planning and reporting requirements is included in state statute (RCW 71.36.005).

GENERAL CONCLUSION

The current situation in Washington mirrors the national pattern where children's mental health care is provided by multiple child-serving systems. Specific goals, eligibility criteria, funding rules, service delivery, and administrative structures differ among these systems. Information about the outcomes, cost, quantity, and quality of these services cannot be determined without making improvements to financial and program data reporting and analysis.

STUDY FINDINGS

Organization and Coordination of Public Mental Health Services for Children

In Washington, a total of nine state-level agencies, administrations, and divisions have responsibility for providing children's mental health-related services. Each has a distinct program and financial structure targeted to specific populations to be served. Due to data limitations and definitional issues, the specific number of children served by all of these agencies cannot be determined.

DSHS contains six of these providing agencies and is the state's social service coordinating and mental health authority. JLARC finds that DSHS has not adjusted its financial or program management activities to systematically coordinate services across DSHS child-serving agencies and programs. This limits the agency's ability to coordinate children's mental health programs and funding.

Coordination of children's mental health services with services from other child-serving entities is carried out by Regional Support Networks (RSNs) at the local level. JLARC finds that some RSNs have developed approaches to work with the state's categorical financial and program structures.

In summary, we find that the legislative intent regarding overall coordination has not been met.

Specific Responsibilities of OFM and DSHS

JLARC finds that OFM and DSHS met the 1991 statutory requirements to create a state plan for EPSDT screenings. That plan, however, has not been updated and is now obsolete.

JLARC also finds that OFM did not develop or maintain an inventory of publicly funded children's mental health services as specified in 1991 legislation.

In order to learn what efforts would be required to develop such an inventory, and how such information might be used, JLARC engaged consultants to develop a limited inventory. One finding from this work is that standard definitions of mental health services can be developed, and information about the array of services available in Washington can be used for service coordination. However, gathering more specific information about service delivery would be difficult and costly to collect and maintain.

Availability and Reliability of Fiscal, Program, and Outcome Information

We reviewed efforts underway by the DSHS Mental Health Division (MHD) to improve the type and quality of information available to manage its mental health system. We also contracted with experts in the field of children's outcomes measurement to review state-of-the-art practices in children's mental health and to provide recommended measures for children. We found:

- DSHS/MHD has undertaken a variety of activities since the 2000 JLARC Mental Health System Performance Audit to improve data quality and collect outcomes information.
- Accurate cost and service data are essential to measuring program outcomes. Throughout the entire children's mental health system, the availability, reliability, and use of fiscal, program and outcome data is limited.

JLARC's consultants developed performance and outcomes measures to provide information about access, quality, outcomes, and cost of care for children.

SUMMARY OF RECOMMENDATIONS

1. DSHS, as a coordinating agency, should identify issues that limit its ability to coordinate children's mental health programs, and should make changes to support cross program collaboration and efficiency.
2. DSHS/MHD should continue to implement and collect reliable mental health cost service data to support an outcome reporting system specific to children's mental health.
3. The Medical Assistance Administration (MAA) and MHD in DSHS should jointly revise the EPSDT plan to reflect the current mental health system structure.
4. The Office of Superintendent of Public Instruction and DSHS/MHD should identify examples of mental health and education systems coordination and share this information among other school districts, Regional Support Networks and other agencies.
5. The Legislature should update statutes to reflect a focus on improvement of cost, service, and outcome data and eliminate the requirement to maintain an inventory of children's mental health services.

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CHAPTER 1 – BACKGROUND

STUDY MANDATE

The 2001-02 Biennial Budget directed the Joint Legislative Audit and Review Committee (JLARC) to study children’s public mental health services in Washington. The proviso was limited in scope and asked JLARC to make recommendations as appropriate for the improvement of services and system performance. Our work focused on the following:

- Review of the structure of children’s mental health service delivery including a limited review of the array of public mental health services available.
- Review of Office of Financial Management (OFM) and Department of Social and Health Services (DSHS) responsibilities specific to development and implementation of plans and services.
- Evaluation of the availability and reliability of fiscal, program, and outcome data, with recommendations for specific performance and client outcome measures for children.

OVERVIEW

Nationally, multiple child-serving systems, including education, mental health, child welfare, developmental disabilities, drug and alcohol, and juvenile justice, provide mental health services to children and youth. This reflects the complicated nature of mental illness and the range of approaches to diagnoses and treatment. According to the U.S. Surgeon General, the distinction between mental health and mental illness is not clear. Mental health diagnoses are made by assessing a range of physical, behavioral, and social conditions in a person’s life, then examining how those conditions relate to one another.¹ Age, gender, ethnicity, cultural background, and socioeconomic status influence understanding of these conditions. These factors result in a broad range of symptoms that may indicate the presence of mental illness, and complicate the diagnosis of mental illness.

The federal government provides Medicaid funding for services to children who are deemed to have serious emotional disturbances. The U.S. Surgeon General reports that in the United States, 11 percent of children and adolescents suffer from mental illness severe enough to cause some level of functional impairment. When extreme

¹ The American Psychiatric Association provides mental illness diagnoses guidelines and criteria for assessing a person in five areas: 1) Clinical Disorders, e.g., mood, anxiety, schizophrenia, cognitive disorders, substance abuse; 2) Personality Disorders – Mental Retardation; 3) General Medical Conditions, e.g., diseases of the blood, nervous system and musculoskeletal system, et al.; 4) Psychosocial and Environmental Problems, e.g., problems with primary support group, educational, economic, housing, social environment, legal system/crime; and 5) Global Assessment of Functioning (GAF) Scoring system of psychological, social, and occupational functioning. Appendix 3 of this JLARC report gives further details and definitions of mental illnesses and behavioral issues related to children’s mental health.

functional impairment is the criterion (which would meet the definition of serious emotional disturbance), the estimate drops to 5 percent.²

CHILDREN’S MENTAL HEALTH SERVICES IN WASHINGTON

Washington’s Community Mental Health Act (RCW 71.24) designates the Department of Social and Health Services (DSHS) as the state mental health authority. However, we found that the organization of children’s mental health services in Washington mirrors the national framework, in that multiple child-serving systems provide mental health services. Nine state-level agencies, administrations, and/or divisions have authority from state law³ for providing children’s mental health-related services (Appendix 3). They are:

Department of Social and Health Services	Department of Community, Trade and Economic Development	K-12 Education System
Juvenile Rehabilitation Administration (JRA) Medical Assistance Administration (MAA) Children’s Administration (CA) Health and Rehabilitative Services Administration <ul style="list-style-type: none"> • Division of Developmental Disabilities (DDD) • Drug, Alcohol and Substance Abuse (DASA) • Mental Health Division (MHD) -14 Regional Support Networks (RSNs)	Early Childhood Education Assistance Program (ECEAP)	Office of the Superintendent of Public Instruction (OSPI) 296 State Public School Districts providing <ul style="list-style-type: none"> • Special Education • Counseling
Economic Services Administration (ESA) <ul style="list-style-type: none"> • Head Start State Collaboration Project – Coordination Activities Only 		

² Burns, et al., 1995, Children’s Mental Health service use by adolescents in the 1970s and 1980s, *Journal of the American Academy of Child and Adolescent Psychiatry* 30, 144-150. Shaffer, et al. 1996, Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 865-877, U.S. Surgeon General Report, 2000.

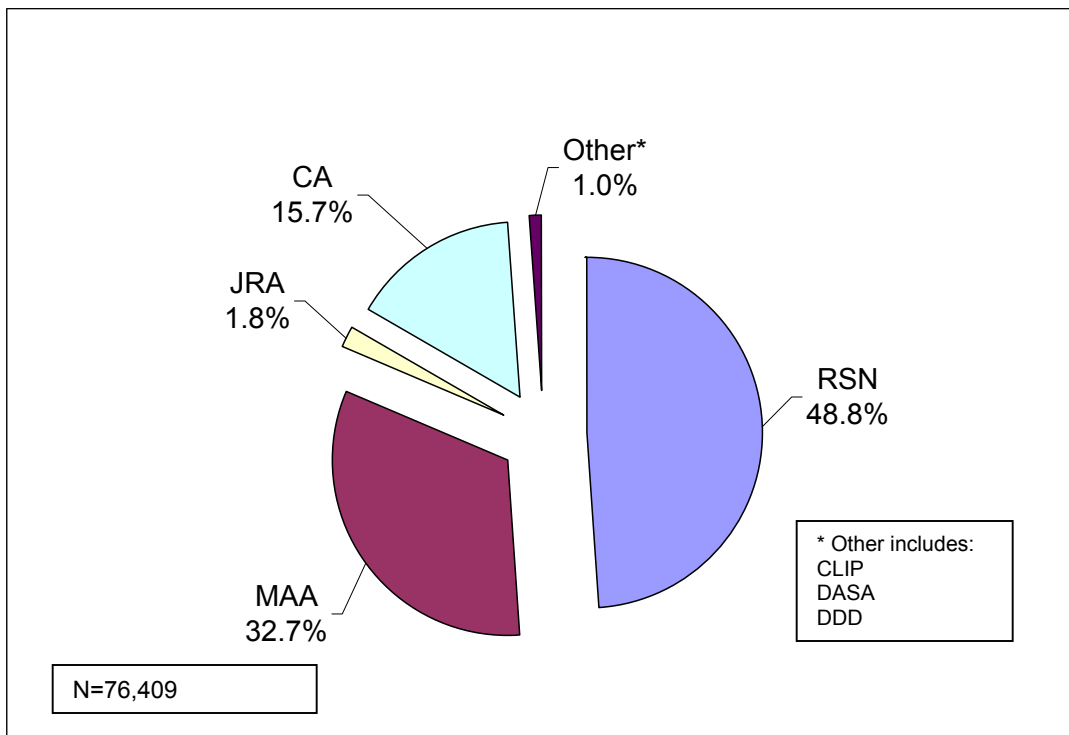
³ The following sections of the Revised Code of Washington outline the complexity of statutes that refer to children’s mental health services.

RCW	TITLE
Chapter 13.32A	Family Reconciliation Act
Chapter 13.40	Juvenile Justice Act of 1977
Chapter 28A.155	Special Education
Chapter 28A.215	Early Childhood, Preschools, and Before-and-After School Care
Chapter 70.96A	Treatment for Alcoholism, Intoxication, and Drug Addiction
Chapter 71.05	Mental Illness
Chapter 71.24	Community Mental Health Services Act
Chapter 71.34	Mental Health Services for Minors
Chapter 71A	Developmental Disabilities
Chapter 74.09	Medical Care (Public Assistance)
Chapter 74.13	Child Welfare Services
Chapter 74.14A	Children and Family Services
Chapter 74.14B	Children's Services
Chapter 74.14C	Family Preservation Services

Each of the entities shown in the chart on the previous page has a distinct program and financial structure targeted to the specific populations to be served. The MHD receives federal Medicaid funding to serve the most seriously emotionally disturbed children.⁴ Later in this report we describe how the RSNs work through coordinating services at the local level. Among the DSHS entities, approximately 76,000 cases received Mental Health services, distributed as shown in Figure 1, below.

The number of children receiving services through Head Start, ECEAP, and the public schools was not available. Although OSPI does not directly provide mental health related services to children, it does channel funds for special education to the state's 296 school districts, and is responsible for collecting information from the districts on how the funds are spent. However, there is no state level aggregation of mental health service data within the education system. Individual schools and local school districts decide whether and which mental health services to provide, and do not report these services beyond the school district level, if at all.

Figure 1
Children Receiving Mental Health Services From DSHS in State Fiscal Year 2000



Source: Clegg and Associates.

⁴ Seriously Emotionally Disturbed is defined as: "A child who has been determined to be experiencing a mental disorder that is clearly interfering with the child's functioning in family, school, or with peers and has undergone inpatient treatment (voluntary or involuntary) in the past 2 years, is currently served by at least one child-serving system, is at risk of escalating maladjustment due to: chronic family dysfunction; changes in custodial adult; involvement in placement outside of the home, subject to repeated physical abuse, drug or alcohol involvement, homelessness."

What Children’s Mental Health Services Are Being Provided?

In order to understand what mental health services are available across the state, and how they compare among child-serving agencies, we initially asked OFM for information on the inventory of services that the Legislature directed OFM in 1991 to develop and maintain. We found that the inventory has never been developed. In response to this finding, JLARC contracted with Clegg and Associates to conduct a limited inventory for the purposes of this review. The aim was to provide basic information for the Legislature about children’s mental health services and their availability, and to learn more about the feasibility of developing an inventory such as the Legislature had requested in 1991.

In conducting this inventory, we found that the programs providing mental health services to children do not use common definitions of what comprises those services. JLARC’s consultants found, however, that many of these differently named services actually reflect the same or similar activities. With this understanding, JLARC’s consultants developed a common set of service categories and definitions. They proved to be comprehensive enough, and with enough description, that the agencies and programs were able to use them to report service information for the inventory. These categories and definitions are shown in Figure 2.

Figure 2
Categories Of Children’s Mental Health Services

Mental health screening:	An assessment or evaluation to determine whether a client has a mental health problem. This may occur at an EPSDT visit or other appointment with a doctor, nurse, case manager, or mental health professional.
Individual counseling or group therapy:	Counseling or group sessions facilitated by a licensed mental health professional, e.g., psychiatrist, psychologist, social worker, or pastoral counselor.
Medication management:	Prescription of psychotropic medication, including anti-depressants, mood stabilizers, psychostimulants, anti-anxiety drugs, and anti-psychotics.
Day treatment:	Age appropriate therapeutic activities provided in a non-residential group setting.
Other outpatient services:	Any other services not covered in the categories above.
Mental health crisis intervention:	Short-term treatment and stabilization in emergency or crisis situations.
Inpatient mental health treatment:	Voluntary or involuntary mental health treatment at an intensely staffed hospital or treatment center, including psychiatric hospitals and evaluation and treatment facilities.
Residential mental health treatment:	Longer-term treatment in a residence where mental health treatment is part of the program.
Mental health case management:	Includes case management provided only by RSNs to enrolled clients.
Involuntary Treatment Act (ITA) investigation:	Determination by a designated Community Mental Health Professional regarding the need for involuntary mental health treatment services.
Screening for admission to state mental health facilities:	Screening for admission to the Child Study and Treatment Center (CSTC) at Western State Hospital.
Screening for admission to mental health residential services:	Screening for admission to the Children’s Long-term Inpatient Program (CLIP).

The value of the common service categories and definitions is that they allow, for the first time, a view of the array of services being provided in Washington, and to display how multiple agencies are providing similar services. Figure 3 on the following page provides

an overview of publicly funded children’s mental health services by agencies and programs, using the service categories developed as part of this review.

Figure 3
Overview of Publicly-Funded Children’s Mental Health Services by Agency and Program

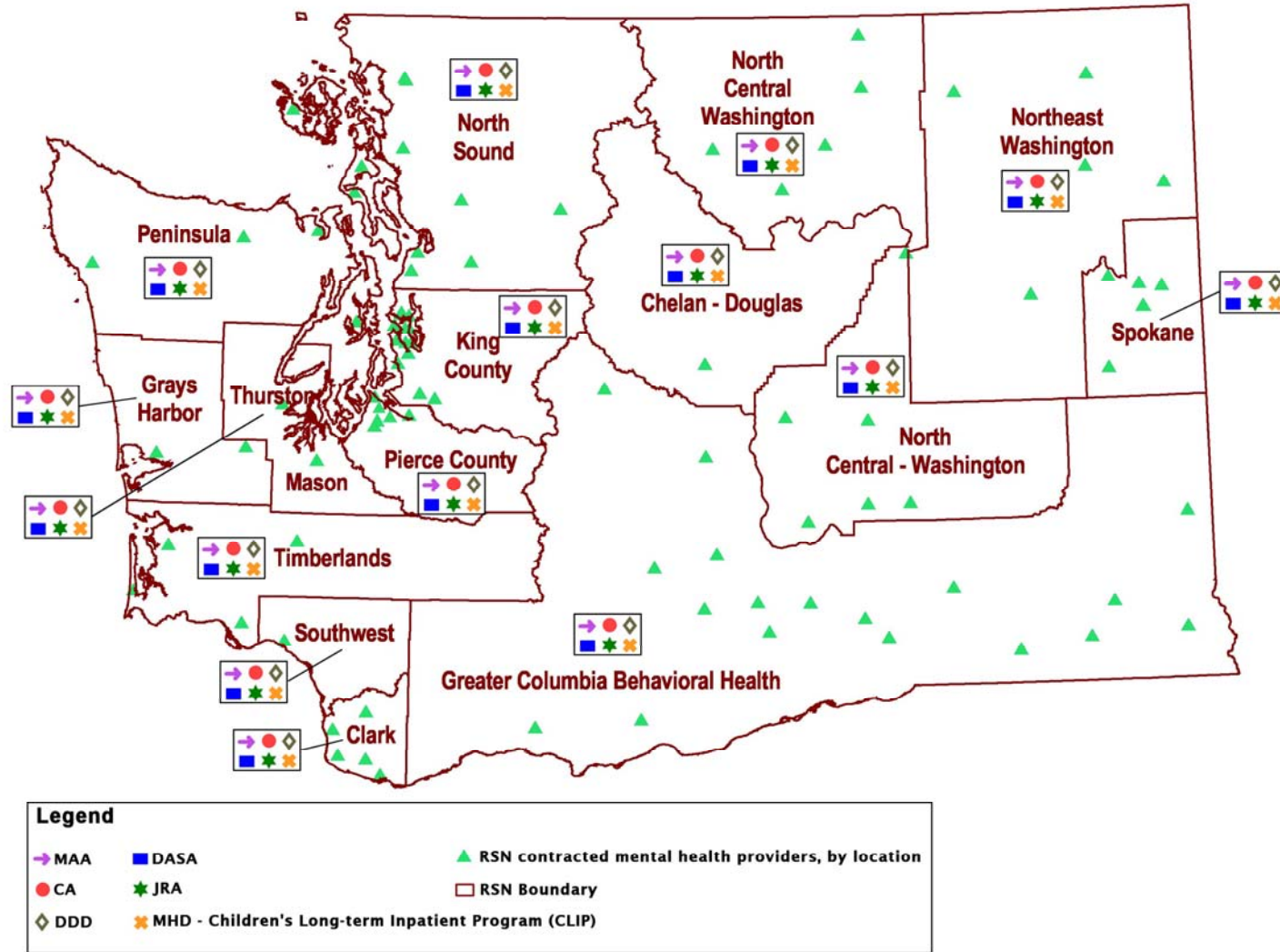
Mental Health Services	DSHS							Education		
	MHD	RSNs	JRA	CA	MAA	DDD	DASA	School Districts	Head Start	ECEAP
MENTAL HEALTH SCREENING		✓	✓	✓	✓	✓		✓	✓	✓
INDIVIDUAL COUNSELING OR GROUP THERAPY		✓	✓	✓	✓	✓		✓	✓	✓
MEDICATION MANAGEMENT		✓	✓		✓					
DAY TREATMENT		Some RSNs		✓			✓			One contractor
OTHER OUTPATIENT SERVICES		Some RSNs	✓	✓		✓				
MENTAL HEALTH CRISIS INTERVENTION		✓		✓	✓					
INPATIENT MENTAL HEALTH TREATMENT		✓								
RESIDENTIAL MENTAL HEALTH TREATMENT	✓	✓	✓	✓						
MENTAL HEALTH CASE MANAGEMENT		✓								
INVOLUNTARY TREATMENT ACT INVESTIGATION		✓								
SCREENING FOR ADMISSION TO STATE MENTAL HEALTH FACILITIES	✓	✓								
SCREENING FOR ADMISSION TO RESIDENTIAL SERVICES	✓	✓								

Information on how these services are arrayed throughout the state can be found in Figure 4 at the end of this chapter. This map shows the RSN-contracted mental health providers as well as access to the other DSHS child-serving agencies. The RSN-contracted providers are dispersed in various localities in each RSN area.

Figure 3 provides information on the services being provided by the agencies and programs, but does not indicate whether these services are non-duplicative or effectively coordinated. The 1991 Legislature further encouraged the development of community-based interagency collaborative efforts to plan for and provide mental health services to

children. RCW 71.36 mandated this planning and coordination. Chapter 2 of this report describes how DSHS, as the state mental health authority, with the RSNs, plan and coordinate mental health services for children. Chapter 3 discusses the availability and reliability of fiscal, program, and outcome data and provides a structure for measuring specific performance and client outcomes for children. Chapter 4 summarizes JLARC's findings and makes five recommendations to improve children's mental health management and service delivery.

Figure 4
 Statewide Array of DSHS Mental Health Services



CHAPTER 2 – PLANNING AND SERVICE COORDINATION

OVERVIEW

The Community Mental Health Act (RCW 71.24) designates the Department of Social and Health Services (DSHS) as the state mental health authority, and directs DSHS to coordinate care across its programs.

The DSHS Mental Health Division (MHD) contracts with 14 county-based Regional Support Networks (RSNs) that plan and administer community-based outpatient and inpatient services for adults and children, and are charged with developing the local mental health program. RSNs operate as comprehensive, prepaid health plans under the state's 1915(b) federal Medicaid waiver. As such, RSNs provide all medically necessary mental health services to eligible children in their catchment areas.

The MHD also operates the Child Study and Treatment Center at Western State Hospital and funds four Children's Long-term Inpatient facilities across the state. In state fiscal year 2000, approximately \$102 million state and federal dollars funded these children's services, including \$60.6 million in capitated payments to RSNs to provide outpatient mental health services to nearly 37,000 children.⁵

The 1991 Legislature enacted the Coordination of Children's Mental Health Services Act (RCW 71.36) to provide for the planning and coordination of mental health services for children, including the federally mandated Early Periodic Screening Diagnosis and Treatment (EPSDT) program. To support this planning effort, the Legislature also directed the Office of Financial Management (OFM) to collect, maintain, and analyze information regarding state and federally funded mental health services provided to children in Washington.

In the following sections of this chapter, we first address whether the overall legislative intent expressed in the Community Mental Health Act and the Coordination of Children's Mental Health Services Act has been met. We next address whether DSHS and OFM have fulfilled their more specific responsibilities within those Acts.

FINDINGS REGARDING OVERALL COORDINATION OF MENTAL HEALTH SERVICES FOR CHILDREN

This study finds that Washington has not met the Legislature's intent to establish a coordinated, efficient and effective system of public mental health care for children. Rudimentary structures are in place to facilitate collaborative efforts, such as the central database MHD maintains that cross-links through the Client Registry to other DSHS databases. However, this study finds that:

⁵ This study cites FY 2000 fiscal and programmatic data because that year was the last full year for which up-to-date information was available while the study was being conducted.

- Although DSHS, as the state mental health authority, has the statutory responsibility to ensure that mental health services are coordinated, we were unable to identify an entity within DSHS that serves as a clearinghouse where changes could be evaluated for implementation across DSHS agencies and programs.
- There are numerous avenues for state agencies to discuss common problems, but there is little evidence that these avenues address systemic issues or that these avenues provide information that is routinely used by agencies to aid them in designing changes to their service delivery systems.
- Systematically across the state, there is no mechanism for blending or braiding multiple funding streams into a single pool to maximize the amount of funds available for services to children. Funding streams continue to be developed and managed separately, depending on the federal fund source and program requirements they are intended to serve.
- The data structure envisioned in statute that would serve as a central repository of information that RSNs could access on an immediate basis to aid them in planning and coordinating the delivery of mental health services does not exist.

Role of the Regional Support Networks

The coordination of children's mental health services at the regional and local levels is a significant part of the RSNs' work, and is a mandated responsibility. The lack of a coherent coordination structure at the state level, however, has meant that the RSNs' coordinating role on the local level has taken on more importance in terms of meeting legislative intent for a coordinated system.

As a backdrop for understanding this role, it is important to note that a large proportion of the children receiving mental health services through the RSNs are also clients of other systems, including drug and alcohol, foster care, children's protective services, developmental disabilities, juvenile rehabilitation, medical assistance, and schools. Each of these agencies delivers mental health services in one form or another to children, and conducts their own assessment to determine the child's needs, what the most appropriate services would be, and programmatic eligibility for a specific target population.

The fact that multiple agencies may be involved with a child often presents a problem when deciding which entity is responsible for providing services in cases with children exhibiting multiple disorders, or whose condition cannot be easily categorized.

This study found that RSNs coordinate services with schools or school districts on an individual basis. Some schools work closely with the RSNs' network of mental health services, while others either provide their own or do not work with RSN providers.

With regard to state agencies, we found there are varying degrees of coordination taking place with the RSNs in their catchment areas. As in the case of school districts, coordination efforts between RSNs and other state agencies primarily occur on a case-by-case basis, using informal methods. This method of coordination relies heavily on personal contacts and relationship building.

Coordination among RSNs takes place on a case-by-case basis as well, with the greatest limiting factor being parent's inconsistency in disclosing when a child is relocating to another RSN. RSNs report that data is not shared electronically, nor in most instances have RSNs established formal coordination procedures.

None of the RSNs have a formal accounting procedure to track service expenditures made for a child crossing RSN boundaries to access specialized services. This may be an area that requires attention from the Mental Health Division, as some of the RSNs report that current administrative procedures associated with funding services for children who need to cross RSN boundaries can be a barrier.

Other Statewide Coordination Efforts

The legislative and executive branches have established, and currently support, a number of avenues by which agencies can identify and discuss common problems, and collaborate on service issues and changes. Some of these include:

- **The Family Policy Council**, established by law in 1992, is charged with making systemic changes to improve outcomes for children and families. One of the Council's main activities is working with the state's Community Public Health and Safety Networks, which are community-based, volunteer boards to help improve the lives of children and families in their communities and provide recommendations for policy changes to improve state and local child- and family-serving systems.
- **The State Interagency Coordinating Council for Infants and Toddlers with Disabilities and their Families** has the mission to coordinate and foster further development of a comprehensive statewide system of accessible local early intervention services for infants and toddlers, from birth to age three with disabilities, or at risk for developing disabilities, and their families and to coordinate transition of these children into programs for 3- to 6-year-olds.
- **No Wrong Door**, a DSHS initiative to help clients who receive more than one service from the agency, deals with policy areas as diverse as alcoholism, aging, juvenile rehabilitation, foster care, developmental disabilities and welfare.

During the course of this JLARC study, we did not find evidence of how the activities of these entities are effectively used for statewide coordination of the delivery of children's mental health services. This finding may be related to the fact that no single entity within DSHS has the responsibility for identifying problems that have systemic themes, coordinating with various agencies on issues that may require cross-agency changes or for incorporating these themes into an integrated mental health delivery system.

FINDINGS REGARDING SPECIFIC RESPONSIBILITIES OF OFM AND DSHS

Early Periodic Screening Diagnosis and Treatment (EPSDT)

Federal law requires states to provide Medicaid eligible children and adolescents 20 years of age and under with access to comprehensive, periodic evaluations of health, developmental, and nutritional status, as well as vision, hearing, and dental services.

The federally required evaluation is referred to as Early Periodic Screening Diagnosis and Treatment, or EPSDT. Components of an EPSDT screen include a comprehensive health and developmental history, a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests (including a blood lead-level assessment), and health education.

In Washington State, the EPSDT program is managed by the Medical Assistance Administration (MAA) within DSHS. MHD and MAA share responsibility for portions of the EPSDT screening instructions, with MHD responsible for articulating the state's guidelines on mental health screenings, and MAA responsible for articulating to providers and managed care organizations specific instructions on the other screening areas, as well as specifying EPSDT operating procedures and billing instructions. MAA currently contracts with the Oregon Medical Professional Review Organization (OMPRO) to conduct an annual case audit program of the EPSDT program and produce an annual EPSDT report.⁶

All contracts currently in place between the Mental Health Division and each RSN specifically call for the RSN to operate an EPSDT screening program in accordance with all applicable laws and the instructions contained in the state EPSDT plan. The plan is the primary guidance the state gives to each RSN on EPSDT screenings for mental health.

The EPSDT plan that the MHD incorporates into each RSN contract was completed in February 1992. This JLARC study finds that much of the specific guidance contained in this plan is outdated, and does not accurately reflect how the program or delivery of mental health services is being operated today. Although out of date, incorporation of this plan into the agreements between the MHD and each RSN contractually requires each to abide by its guidance. This is of concern, because the experience of several states and a national study⁷ indicates that contracts between states and their contractors which are worded ambiguously may leave states with significant liability if the contractor does not take all the steps required to provide EPSDT services.

Inventory of Publicly Funded Mental Health Services for Children

As mentioned in Chapter 1, JLARC found that OFM did not develop or maintain an inventory of publicly funded children's mental health services as specified in the 1991 legislation. The inventory of the array of services was to provide information about the types of services available across the broad group of child-serving entities,⁸ and was to include information about the number of children served, their ethnicity and the cost of services being delivered. This inventory was of interest to executive branch agencies in

⁶ The 2001 EPSDT screening data from OMPRO show that 1.1 percent of children who had been screened were subsequently referred for mental health evaluations. This number is low in comparison to the Surgeon General's estimate that 5 percent of children have extreme functional impairments. We were unable, from the data available from DSHS, to determine the reason for this apparent discrepancy. DSHS (MHD and MAA) efforts to monitor the implementation of EPSDT screenings for mental health clients are limited.

⁷ Rosenbaum, S, Sonosky, C, Shaw, K, and Zakheim, M. *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, 3rd Edition, Key Findings in Pediatric Services and Coverage, June 1999.

⁸ RCW 71.36.020(1)(a) ... "children's mental health services" shall be broadly construed to include services related to children's mental health provided through education, children and family services, juvenile justice, mental health, health care, alcohol and substance abuse, and developmental disabilities...

1991 as they were attempting to bring about a coordinated service delivery system for children.

In conducting this study, we learned that legislators and stakeholders were still interested in understanding the similarities and differences in service availability and structures across the state. Accordingly, JLARC contracted with Clegg and Associates, who worked with the Health Policy Analysis Program (HPAP) at the University of Washington, to conduct a limited review of children's mental health services (Appendix 4). Their findings include the following:

- The array of publicly funded mental health services available to children is basically the same across the state. Minor exceptions include the availability of day treatment and special outpatient services provided to meet local needs. (See Chapter 1 for descriptions of day treatment and special outpatient services. These services are available only in some areas.)
- How successfully children across the state can access this array of services cannot be determined. Access to services is influenced by location, capacity, and eligibility, and information about these factors is not collected, maintained, or evaluated.
- The intensity or the amount of services received by children is not known, nor is the cost or quality of services provided.
- DSHS data systems do not track or support analysis of regional or countywide comparisons of service delivery across child-serving administrations or divisions.
- Washington's education system (OSPI, ESDs, local school districts) does not have data that allows monitoring of type, costs, or intensity of services at individual school or school district levels.
- Eligibility criteria of the differing child-serving systems vary according to the federal and/or state statutory directions for the programs. Depending on the system, these criteria focus on clinical issues, financial qualifications, geographic specifications, or a combination of these factors. Agencies providing the services often conduct their own assessments to determine whether the child is eligible for services, what the child's needs are, and what services might be most appropriate. Each program has a specific set of services intended to meet the needs of a particular target population, and there is considerable overlap among these various target populations. This leads to service delivery systems that provide similar or parallel services. In addition, service level eligibility criteria across these delivery systems also vary.

Lessons Learned from Inventory

This JLARC study is the first time information about the broad array of publicly funded mental services for children has been collected. This inventory developed a definition of mental health services that was consistent with statutory intent and understandable to

the child-serving systems across the state. It identified realistic approaches to standardizing some of the data fields of DSHS children's mental health-serving systems to more readily estimate the number of children that received mental health services. This information could assist child-serving agencies to better meet the legislative intent of coordinated service delivery, which could, in turn, promote maximizing and blending program and fiscal resources and reducing duplicative case management.

Providing a full inventory of services that would give details on children's access to services and their service utilization, however, was beyond the scope of this JLARC study. We conclude that maintaining such an inventory would require additional data collection that would not necessarily provide practical answers to, or information concerning, issues surrounding the effectiveness of the delivery of services to children with mental health service needs.

A more practical emphasis would be first to monitor whether the mental health system is achieving the outcomes of interest to legislators, administrators, and stakeholders: Are children improving, what is the cost, and how is improvement achieved? In Chapter 3 we identify data collection and analysis activities where further work could be justified to improve cost, service, and outcome data.

CHAPTER 3 – FISCAL, PROGRAM, AND OUTCOME INFORMATION ABOUT CHILDREN'S MENTAL HEALTH

BACKGROUND

Accurate and reliable information about the cost and types of service provided to clients, and whether the services make a difference, is essential for monitoring and managing mental health system resources. The 2001 legislative mandate for this study directed JLARC to assess the reliability of cost, service, and outcome data specific to children. Our 2000 JLARC Mental Health System Performance Audit previously reviewed the quality of mental health system cost, service, and outcome data, and recommended improvements in the type and quality of data collected. The audit also recommended a framework of outcome measures that could be used to measure system performance to improve data collection activities.

JLARC reviewed the Mental Health Division's efforts that are underway to improve data collection activities. In addition, JLARC contracted with Dougherty Management Associates, experts in the field of children's mental health outcomes, to identify state-of-the-art performance indicators and outcome measurement for children. The collection and reporting of data within Washington State as well as national children's mental health outcome initiatives were reviewed, as was the measurement framework laid out in the 2000 JLARC Performance Audit. Analysis of this information led to the development of the core set of measures specific to children, which are provided below. (A more detailed discussion of these measures is located in Appendix 5.)

Improvements Made by MHD

Overall, the MHD has made progress in its efforts to improve the quality of its data. Continued interest by the Legislature and DSHS to use the information to assess system performance are key to moving the mental health system toward greater accountability and system improvements. We find that the MHD has been proactive in making a number of changes⁹ in response to the 2000 JLARC report. Specifically:

- Reporting on 12 of the 23 JLARC measures was incorporated into MHD 2001-03 contracts with RSNs. MHD plans to phase-in collection of additional measures over the course of the contract period.
- MHD worked with key system stakeholders and issued a contract in May 2002 to develop a comprehensive consumer outcome system. This system, planned for pilot testing in fall 2002, will include measurement of client change as a result of services received.

⁹ These changes are recent and early baseline data is not expected until later in 2002. MHD will be providing a follow-up report to JLARC on implementation of its 2000 audit recommendations. This will include a review of the results of changes to the data systems and preliminary analysis of baseline outcome and performance indicator data.

- MHD Consumer Information System Data Dictionary was updated in January 2002.
- MHD fiscal staff are studying RSN and provider accounting and reporting activities to identify consistency issues and reporting difficulties. Recommendations for clarity and consistency are expected to be complete in 2002.

Although the full impacts of these recent MHD efforts cannot be assessed yet, MHD is taking action to implement these important steps toward improving its management of the mental health system.

Measures Specific to Children

Informed budget and policy decisions rely not only upon accurate cost and service information, but also upon whether the services being purchased are having their desired results. RSNs and providers need information to monitor performance, identify trends, and make comparisons with similar organizations.

Our review of the 2000 JLARC framework of measures for the entire mental health system, and other national and state initiatives, resulted in the development of core measures for children. These measures answer the following basic questions needed to effectively manage the children's mental health system:

- How many children are being served?
- What types of services are provided?
- At what cost?
- Have the children improved while receiving these services?

Data Specific to Children Needs Improvement

To answer these questions, the MHD needs to make further improvements to data collection activities so the appropriate information is available to manage the children's mental health system:

- MHD does not currently report expenditure or cost data by age. Therefore, critical cost indicators such as cost per individual served or cost per unit of service cannot be reported separately for children.
- RSNs vary in the type and quality of outcome information collected about the children they serve.
- RSNs are expecting leadership and guidance from MHD regarding clinical outcome measures.

- Administration of the Child Global Assessment Scale (CGAS)¹⁰ instrument appears inconsistent across RSNs. Some RSNs are not administering the CGAS even though results are a required element in the revised MHD data dictionary.

Dougherty Associates developed the following set of core measurements that are intended to give stakeholders a focused way to monitor system performance. Given that reliable cost, service, and outcome data are needed to manage and monitor the children's mental health system, JLARC incorporates implementation of this framework in Recommendation 2, which is provided in Chapter 4 of this report.

Framework of Performance And Outcomes Measures Specific to Children

Access:

1. Penetration rate*
2. Utilization rate for specific service types**
3. Consumer/family perception of access

Quality/Appropriateness:

4. Consumer/family perception of quality/appropriateness
5. Consumer/family perception of their participation in decision-making
6. Follow- up after hospital discharge within seven days
7. 30-day readmission rate

Outcomes:

8. Client change in symptoms as a result of the services provided
9. Clients who have stable living situations or maintain community placement
10. Juvenile justice involvement rate (percentage of clients without a detention stay)
11. Substance abuse services rate (percentage of clients receiving drug and alcohol services)

Structure/Plan Management (Financial):

12. RSN service expenditures per child served
13. RSN service expenditures per unit of service (for specific service types)

*Penetration rate is the proportion of a specified population that received a mental health service. It is calculated by dividing the unduplicated number of individuals who received a mental health service by the total covered population.

**Utilization rate measures the use of a single service or type of service, e.g., hospital care or outpatient services. It is usually expressed in rates per unit of population for a given period.

Dougherty Management Associates, Inc.

¹⁰ Child Global Assessment Scale (CGAS) is an outcomes measurement/assessment instrument specific for children/youth. It is used to assess psychological, social, and other factors relevant to a child's level of functioning.

CHAPTER 4 – CONCLUSIONS AND RECOMMENDATIONS

This concluding section draws upon several parts of our study to make recommendations to streamline and better integrate mental health programs and services for children by more systematically collecting, analyzing, and reporting service outcomes and costs.

Coordination and Efficiency

We found that in Washington State, a total of nine state-level agencies, administrations, and divisions have responsibility for providing children’s mental health-related services. Each has a distinct program and financial structure targeted to specific populations of children to be served. Although the Department of Social and Health Services (DSHS) contains six of these providing entities and is the state’s social service coordinating and mental health authority, we found the Department has not adjusted its financial or program management activities to systematically coordinate services across its child-serving divisions and programs. This limits its ability to coordinate children’s mental health programs and funding.

Coordination of children’s mental health services with services from other child-serving agencies and entities including school districts is carried out by Regional Support Networks (RSNs) at the local level. JLARC finds that some RSNs have developed approaches to work with the state’s categorical financial and program structures, but there is no consistency statewide.

Recommendation 1

The Department of Social and Health Services should identify DSHS cross-agency business operation issues that limit their ability to meet statutory intent to coordinate existing categorical children’s mental health programs and funding. The Department of Social and Health Services should report to the appropriate standing committees of the Legislature those changes it will make to its financial and administrative structure to support field-level cross-program collaboration and efficiency.

Legislation Required:	No
Fiscal Impact:	No
Completion Date:	June 2003

Cost, Service, and Outcome Information

Accurate and reliable information about the cost and types of service provided to clients, and whether the services make a difference is essential for monitoring and managing mental health system resources. We found that the MHD has undertaken a variety of activities since the 2000 JLARC Mental Health System Performance Audit to improve data quality and collect outcomes information. However, we also found that cost data

specific to children's outpatient services is not collected by the MHD and service and outcome data is limited and is not standard across the state.

Recommendation 2

The Department of Social and Health Services' Mental Health Division (MHD) should collect reliable mental health cost, service, and outcome data specific to children to be consistent with the framework of children's outcomes measures described in this report. This information should be used to identify best practices and costs of services. The MHD should continue efforts to implement the JLARC 2000 framework, and provide routine status reports to appropriate standing committees and stakeholders on the analysis of information collected about mental health system outcomes. The MHD should report to JLARC at its January 2003 meeting on how it is progressing in the implementation of this recommendation.

Legislation Required:	No
Fiscal Impact:	Yes (Legislature already provided a total of \$822,000 state and federal funds in the 2001-2003 Biennial Budget consistent with 2000 JLARC Performance Audit).
Completion Date:	January 2003 and ongoing

State Plan for EPSDT Program

The Office of Financial Management and DSHS met the 1991 statutory requirements to create a state plan for implementing the Early Periodic Screening, Diagnosis, and Treatment screening program (EPSDT). EPSDT is a component of the federal Medicaid program that requires comprehensive health evaluations for Medicaid eligible children. It is implemented in Washington by the DSHS Medical Assistance Administration, with the MHD responsible for providing guidance to mental health providers. The plan has not been updated since 1992 and the MHD continues to incorporate this original plan into its contracts with the RSNs. Much of the specific guidance in the plan is outdated and does not accurately reflect how mental health services are delivered today. In order for the state to properly fulfill federal requirements, the current plan should be updated.

Recommendation 3

The Department of Social and Health Services Medical Assistance Administration and the Mental Health Division should revise the Early Periodic Screening Diagnosis and Treatment plan to reflect current mental health system structure.

Legislation Required:	No
Fiscal Impact:	No
Completion Date:	September 2002

OSPI and DSHS Coordination

This study found that mental health services are provided by public schools, but state level aggregation of mental health service data within the education system does not exist. The Office of the Superintendent of Public Instruction (OSPI) does not provide mental health services, but does channel funds for these special education services to

the state's 296 school districts and is responsible for collecting information from the districts on how these funds are spent. Individual schools and local school districts decide whether and which mental health services to provide, and do not report these services beyond the school district level, if at all. Coordination between OSPI and the Mental Health Division is limited. The Regional Support Networks coordinate services with schools or school districts on an individual basis. Some schools work closely with the RSNs' network of mental health services, while others either provide their own or do not work with RSN providers.

Recommendation 4

The Office of Superintendent of Public Instruction and Department of Social and Health Services' Mental Health Division should jointly identify school districts where mental health and education systems coordinate services and resources to provide public mental health care for children. These agencies should work together to share information about these approaches among other school districts, RSNs, and state agencies.

Legislation Required:	No
Fiscal Impact:	No
Completion Date:	January 2003 and ongoing

Statutory Updates and Changes

The Office of Financial Management was directed in 1991 to develop and maintain an inventory of publicly funded children's mental health services to support community planning activities. Early on in our study, we found the inventory had not been completed or maintained. In response to this finding, JLARC sought to learn what efforts would be required to develop such an inventory, and how such information might be used. Although collecting some of the information about the array of services could be useful, much of the other information from a full inventory would be difficult and costly to collect. A more practical effort would be to monitor whether the mental health system is achieving the outcomes of interest to legislators, administrators and stakeholders, i.e., are children improving, what is the cost, and how is improvement achieved.

Recommendation 5

The Legislature should update statutes (RCW 71.36) to reflect their interest in the Mental Health Division providing accurate and reliable cost, service and outcome data about the children's mental health system and eliminate the requirement for the Office of Financial Management to collect and maintain an inventory of children's mental health services.

Legislation Required:	Yes
Fiscal Impact:	No
Completion Date	June 2003

AGENCY RESPONSES

The Department of Social and Health Services (DSHS) and the Office of Financial Management (OFM) concur or partially concur with all five of the JLARC recommendations. Both agencies are interested in improving the quality of cost, program, and outcome information without imposing unnecessary administrative burden.

The Office of the Superintendent of Public Instruction (OSPI) concurred with Recommendation 4, the only recommendation directly applicable to that agency.

ACKNOWLEDGEMENTS

We appreciate the cooperation and assistance provided by Richard Onizuka, Judy Hall, and Sabine Whipple of the Department of Social and Health Services Mental Health Division; Kari Burrell, Office of Financial Management; The Regional Support Networks; and The Washington Community Mental Health Council.

We are also thankful to Clegg and Associates and Dougherty Management Associates, Inc. for their assistance with this study.

This study was conducted by Valerie Whitener, Bree Ramage, and Shayne Frost of the JLARC staff with Bob Thomas serving as project supervisor.

Thomas M. Sykes
Legislative Auditor

On August 7, 2002, this report was approved for distribution by the Joint Legislative Audit and Review Committee.

Representative Val Ogden
Chair

APPENDIX 1: SCOPE AND OBJECTIVES

Children's Mental Health Study

SCOPE AND OBJECTIVES

OCTOBER 31, 2001



STATE OF WASHINGTON
JOINT LEGISLATIVE AUDIT AND
REVIEW COMMITTEE

STUDY TEAM

VALERIE WHITENER
SHAYNE FROST

LEGISLATIVE AUDITOR

TOM SYKES

Joint Legislative Audit & Review Committee
506 16th Avenue SE
Olympia, WA 98501-2323
(360) 786-5171
(360) 786-5180 Fax
Website: <http://jlarc.leg.wa.gov>
e-mail: neff_ba@leg.wa.gov

MANDATE

The 2001-03 Biennial Budget directs JLARC to study children's public mental health services in Washington. This proviso is limited in scope and asks JLARC to:

- **review plans and services** for children, including those for early periodic screening, diagnosis, and treatment efforts (*otherwise known as EPSDT*), as directed by RCW 71.36.020;
- **review implementation of those plans;**
- **review the availability and reliability of fiscal, program, and outcome data** relating to mental health services provided to children; and
- **survey mental health services for children** provided among the state's Regional Support Networks (RSNs).

The proviso also asks JLARC to make recommendations as appropriate for the improvement of services and system performance, including the need for performance and client outcome measures for publicly funded mental health services for children. The 2001 Legislature provided \$140,000 in additional resources for JLARC to undertake this assignment. The study is due to the Legislature by July 1, 2002.

BACKGROUND

In 1991 the Legislature wanted to encourage the development of community-based interagency collaborative efforts to plan for and provide mental health services to children. RCW 71.36 mandated the coordination of mental health services for children.

That 1991 statute directed the Office of Financial Management (OFM) to create and maintain an inventory of state and federally funded mental health programs for children. That inventory was to include caseload, cost, and service data for the multiple systems that provide public mental health services to children. In addition, OFM was directed to work with the Department of Social and Health Services (DSHS) to develop plans and criteria for the use of early periodic screening, diagnosis, and treatment services (EPSDT) related to mental health.

That 1991 statute also required that RSNs work with DSHS program areas (i.e., Children and Family Services, Medical Assistance Administration, Mental Health, Juvenile Rehabilitation, Alcohol and Substance Abuse, and Developmental Disabilities). These mandated collaborative efforts were intended to develop and provide mental health services delivery plans to coordinate funding for existing services, to reduce duplication in service delivery, and to promote complementary services among all organizations that provide children's services related to mental health in Washington.

STUDY SCOPE

JLARC's mandated study has a limited scope and will **not** include an evaluation of the varieties of unmet needs for the provision of children's mental health services in Washington State. The JLARC study **will** assess

coordination of children’s mental health services required by RCW 71.30. The study **will** also review the availability of fiscal, program, and outcome data for currently provided children’s mental health services, and **will** provide a survey of public mental health services for children in each of Washington’s regional support networks.

STUDY OBJECTIVES

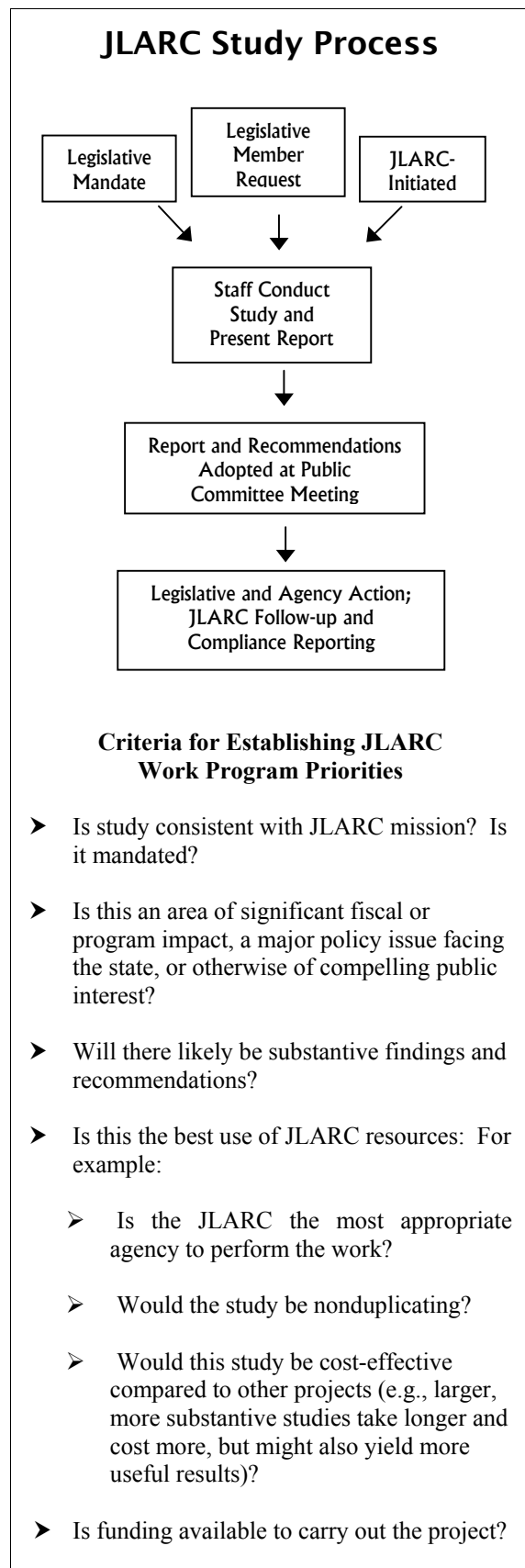
1. Assess the adequacy of OFM’s and DSHS’s efforts to collect, maintain, and analyze state and federally funded mental health services provided to children in Washington. Review to what extent that information is used in planning coordinated children’s mental health services. Recommend alternatives, if appropriate, to current DSHS and OFM efforts.
2. Evaluate OFM’s and DSHS’s success in meeting statutory responsibilities to facilitate interagency collaborative efforts. Determine the extent to which those efforts have led to coordinated mental health services for children, increased opportunity for integration of categorically funded programs, and reduced duplicative case management. Recommend changes and different directions where appropriate.
3. Review the adequacy of OFM’s and DSHS’s plans and criteria for the use of early periodic screening, diagnosis, and treatment services related to mental health. Recommend changes and different directions where appropriate.
4. Assess the efforts of the RSNs to meet statutory responsibilities to develop and implement plans for coordinated children’s mental health services. Determine the adequacy of these efforts and suggest alternative directions, if appropriate.
5. Assess the availability and reliability of fiscal, program, and outcome data for children’s mental health services. Outline alternative approaches for producing reliable fiscal, program and outcome information.
6. Survey children’s mental health services provided in the 14 RSNs. Outline the level of services provided through the RSNs in light of the legislative intent associated with the 1991 statute referenced above.

TIMEFRAME FOR THE STUDY

Our JLARC work schedule assumes that a preliminary report will be completed and presented to JLARC at its June 2002 meeting.

JLARC STAFF CONTACT FOR THE STUDY

Valerie Whitener (360) 786-5181 whitener_vp@leg.wa.gov
 Shayne Frost (360) 786-5198 frost_sh@leg.wa.gov



APPENDIX 2: AGENCY RESPONSES

- Department of Social and Health Services (DSHS)
- Office of Financial Management (OFM)
- Office of the Superintendent of Public Instruction (OSPI)



STATE OF WASHINGTON
 DEPARTMENT OF SOCIAL AND HEALTH SERVICES
 Olympia, WA 98504-5000

RECEIVED
 JUL 16 2002
 JLARC

July 11, 2002

TO: Thomas M. Sykes, Legislative Auditor
 Joint Legislative Audit and Review Committee

FROM: Dennis Braddock
 Secretary

SUBJECT: CHILDREN'S MENTAL HEALTH STUDY – PRELIMINARY REPORT

Thank you for the opportunity to provide our response to your preliminary report on the Children's Mental Health Study. Our comments are provided below:

RECOMMENDATION	AGENCY POSITION	COMMENTS
1. DSHS, as a coordinating agency, should identify issues that limit its ability to coordinate children's mental health programs, and should make changes to support cross program collaboration and efficiency.	Concur	
2. DSHS/MHD should continue to implement and collect reliable mental health cost service data to support an outcome reporting system specific to children's mental health.	Partially Concur	DSHS/MHD will continue with outcomes per 2000 JLARC report (pending continual funding). MHD would like to work with JLARC regarding "routine status reports", and description of cost data.
3. MAA and MHD in DSHS should jointly revise the EPSDT plan to reflect the current mental health system structure.	Concur	
4. The Office of the Superintendent of Public Instruction and DSHS/MHD should identify examples of mental health and education systems coordination and share this information among other school districts, Regional Support Networks and other agencies.	Partially Concur	DSHS/MHD will initiate efforts with OSPI to develop examples of progressive coordination between mental health and education systems.

5. The Legislature should update statutes to reflect a focus on improvement of cost, service, and outcome data and eliminate the requirement to maintain an inventory of children's mental health services.	Concur	
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DSHS/Mental Health Division staff will work with JLARC staff to strike a balance between providing information and data in reports back to the legislature while also not imposing any unnecessary administrative burden. We will also work with JLARC staff to coordinate reports with reports based on the 2000 JLARC study.

Again, thank you for the opportunity to comment. If you have questions or need additional information, please let me know.

- cc: Karl Brimner, MHD
- Richard Onizuka, MHD
- Steve Norsen, MHD
- Sabine Whipple, MHD
- Kari Burrell, OFM



RECEIVED
JUL 15 2002
JLARC

STATE OF WASHINGTON

OFFICE OF FINANCIAL MANAGEMENT

Insurance Building, PO Box 43113 • Olympia, Washington 98504-3113 • (360) 902-0555

July 12, 2002

Tom Sykes
Joint Legislative Audit and Review Committee
506 16th Avenue SE
Olympia, WA 98501-2323

Dear Mr. Sykes:

Thank you for the opportunity to review the Joint Legislative Audit and Review Committee's preliminary report entitled **Children's Mental Health Study**. Below are the Office of Financial Management's comments regarding the report's recommendations.

RECOMMENDATION	OFM POSITION	COMMENTS
Recommendation 1: DSHS should identify cross-agency operation issues that limit the coordination of children's mental health programs and funding and report to the legislature what changes will be made to financial and administrative structures.	Concur	
Recommendation 2: DSHS' Mental Health Division should collect mental health cost, service and outcome data specific to children and report to the legislature in January 2003 on progress.	Partially concur	The interest in good data should be tempered with an awareness of the costs (particularly for the RSNs) in collecting the data. OFM therefore supports a prioritized data collection effort.
Recommendation 3: DSHS' Mental Health Division and Medical Assistance Administration should update the EPSDT plan.	Concur	
Recommendation 4: OSPI and DSHS should identify school districts where mental health and education systems coordinate mental health services and resources for children, and share this best practice information.	Concur	DSHS will need cooperation from both OSPI and the RSNs to successfully implement this item.



Tom Sykes
Joint Legislative Audit and Review Committee
July 12, 2002
Page 2

<p>Recommendation 5: The legislature should update RCW 71.36 to reflect interest in Mental Health Division providing accurate cost, service, and outcome data about children's mental health system and eliminate the requirement for OFM to collect and maintain an inventory of children's mental health services.</p>	<p>Concur</p>	<p>OFM supports a streamlined and prioritized approach to data collection. Although good data is essential for program planning and evaluation, resources expended on data collection are necessarily resources that cannot be expended on direct mental health treatment services for children. OFM therefore supports a limited data collection approach focused on outcomes.</p>
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We believe the recommendations in this report outline appropriate next steps the state can take to assist communities in developing and evaluating coordination efforts in the arena of children's mental health at the local level. Once again, thank you for the opportunity to comment.

Sincerely,


Marty Brown
Director

Cc: Wolfgang Opitz, OFM
Kari Burrell, OFM
Wayne Kawakami, OFM
Dennis Braddock, DSHS
Stan Marshburn, DSHS
Karl Brimmer, DSHS MHD



SUPERINTENDENT OF PUBLIC INSTRUCTION

DR. TERRY BERGESON OLD CAPITOL BUILDING • PO BOX 47200 • OLYMPIA WA 98504-7200 • <http://www.k12.wa.us>

July 25, 2002

RECEIVED

JUL 25 2002

JLARC

Dr. Thomas M. Sykes, Legislative Auditor
Joint Legislative Audit and Review Committee
P. O. Box 40910
Olympia, WA 98504-0910

Dear Dr. Sykes:

Thank you for the opportunity to review and comment on the Joint Legislative Audit and Review Committee's (JLARC) preliminary report of the Children's Mental Health Study.

In response to your request, my staff and I have reviewed Study Recommendation 4, and concur with the conclusions reached by JLARC staff.

The Office of Superintendent of Public Instruction welcomes the opportunity to work with the Department of Social & Health Services to identify and disseminate examples of effective partnerships between the education and mental health systems. I believe we can absorb this work into our existing efforts.

Sincerely,

Dr. Terry Bergeson
State Superintendent of Public Instruction

by

Marcia Riggers
DR

Marcia Riggers
Assistant Superintendent
Operations and Support

APPENDIX 3 – STATUTORY AUTHORITY FOR CHILDREN’S MENTAL HEALTH SERVICES IN WASHINGTON STATE

Nine respondent agencies, administrations, and divisions derive authority for providing children's mental health-related services from at least 14 chapters of the RCW.¹¹ In addition to statutory authority not being the same for all nine entities, service definitions and child eligibility definitions (most often described by a type of mental illness or condition) contained within the statutes often are not the same. Yet many of the differently name services and child eligibility descriptions actually reflect the same or similar activities or eligibility standards.

RCW	TITLE
Chapter 13.32A	Family Reconciliation Act
Chapter 13.40	Juvenile Justice Act of 1977
Chapter 28A.155	Special Education
Chapter 28A.215	Early Childhood, Preschools, and Before-and-After School Care
Chapter 70.96A	Treatment for Alcoholism, Intoxication, and Drug Addiction
Chapter 71.05	Mental Illness
Chapter 71.24	Community Mental Health Services Act
Chapter 71.34	Mental Health Services for Minors
Chapter 71A	Developmental Disabilities
Chapter 74.09	Medical Care (Public Assistance)
Chapter 74.13	Child Welfare Services
Chapter 74.14A	Children and Family Services
Chapter 74.14B	Children's Services
Chapter 74.14C	Family Preservation Services

Table B1 provides a summary of the statutory authority under which each of the respondent agencies, administrations, and divisions provides children's mental health-related services. The authority for Head Start is found exclusively in federal statutes and regulations.

Table B2 provides a summary of the language in each statute regarding the mental illness or behavioral issues addressed and the services provided.

¹¹ Source: Clegg and Associates Report, Appendix D.

Children's Mental Health Study

TABLE B1:
Statutory Authority for Publicly Funded Children's Mental Health Services, as Reported by Respondents

Mental Health Services	DSHS						
	MHD	RSNs	JRA	CA	MAA	DDD	DASA
Mental Health Screening		RCW 71.24.025 WAC 388- 865-0230	RCW 13.40	RCW 74.14A.050 RCW 74.14A.020	RCW 74.09 WAC 388-534		
Individual Counseling or Group Therapy		RCW 71.24.025 WAC 388- 865-0230	RCW 13.40	RCW 74.14C.005 RCW 13.32A.040 RCW 74.13.075 RCW 74.14A.020	RCW 74.09 WAC 388-529	RCW 74.13.350 RCW 71A.12.040	
Medication Management		RCW 71.24.025 WAC 388- 865-0230	RCW 13.40		RCW 71.24 RCW 71.34 WAC 388-865 RCW 74.09 WAC 388-529		
Day Treatment		WAC 388- 865-0230	RCW 13.40	RCW 74.14B.040 "Rehabilitation section of the Medicaid State Plan"			RCW 70.96A
Other Outpatient Services		RCW 71.24.025		RCW 74.14A.020	RCW 74.09 WAC 388-529	RCW 74.13.350	
Mental Health Crisis Intervention		RCW 71.24.025 WAC 388- 865-0230	RCW 13.40	RCW 74.14A.020,030 WAC 388-148 "Rehabilitation section of the Medicaid State Plan"	RCW 74.09 WAC 388-529		
Inpatient Mental Health Treatment		RCW 71.24.025			RCW 71.24 RCW 71.34 WAC 388-865		
Residential Mental Health Treatment		RCW 71.24.025	RCW 13.40	RCW 74.14A.020,030 WAC 388-148 "Rehabilitation section of the Medicaid State Plan"	RCW 71.24 RCW 71.34 WAC 388-865		

Children's Mental Health Study

Mental Health Services	DSHS						
	MHD	RSNs	JRA	CA	MAA	DDD	DASA
Mental Health Case Management		RCW 71.24.025					
Involuntary Treatment Act Investigation		RCW 71.24.025					
Screening for Admission to State Mental Health Facilities							
Screening for Admission to Residential Services		RCW 71.24.025 WAC 388-865-0230					

Mental Health Services	School Districts	ECEAP	Head Start
Mental Health Screening	RCW 28A.155.090 WAC 392-172-010 34 CFR 300	RCW 28A.215.100	Head Start Act (Title VI, Subtitle A, Chapter 8, Subchapter B of Public Law 97-35), as amended. Codified at 42 USC 9831-9843a.
Individual Counseling or Group Therapy	WAC 392-172-055	RCW 28A.215.100	42 USC 9831-9843a (P.L. 97-35) (45 CFR 1301-1308)
Medication Management			
Day Treatment		RCW 28A.215.100	
Other Outpatient Services			
Mental Health Crisis Intervention			
Inpatient Mental Health Treatment			
Residential Mental Health Treatment			
Mental Health Case Management			
Involuntary Treatment Act Investigation			
Screening for Admission to State Mental Health Facilities			
Screening for Admission to Residential Services			

TABLE B2:
Review of Statutory Authority for Publicly Funded Children's Mental Health Services

Agency	Laws & Agency Rules	Services Provided	Mental Illnesses/Behavioral Issues Covered
<p>Mental Health Division (MHD)</p>	<p>Chapter 71.05 RCW: Mental Illness</p> <p>WAC 388-865: Community Mental Health and Involuntary Treatment Programs</p>	<ul style="list-style-type: none"> ● EPSDT screening and treatment. (WAC 388-865-0350) ● Inpatient services. (WAC 388-865-0229) ● Community support services: <ul style="list-style-type: none"> - Emergency crisis intervention - Case mgmt. - Psychiatric treatment including medication supervision; - Counseling and psychotherapy - Day treatment - Complete screening for persons being considered for admission to residential services (WAC 388-865-0230) ● Residential and housing services (WAC 388-865-0235) 	<ul style="list-style-type: none"> ● Acutely mentally ill children. This includes: <ul style="list-style-type: none"> - A mental disorder, defined as "any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions. The presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior, or mental retardation alone is insufficient to justify a finding of 'mental disorder' within the meaning of this section." (RCW 71.34.020(13), as referenced by 71.24.025(1)(a)) - Being gravely disabled, defined as "a minor who, as a result of a mental disorder, is in danger of serious physical harm...or manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions..." (RCW 71.34.020(8), as referenced by 71.24.025(1)(b)) - Presenting a likelihood of serious harm, defined as either inflicting physical harm on him/herself, or inflicting physical harm on another, or inflicting physical harm on the property of others. (RCW 71.34.020(11), as referenced by 71.24.025(1)(b)) ● Severely emotionally disturbed children, defined as: "a child who has been determined by the RSN to be experiencing a mental disorder as defined in chapter 71.34 RCW, including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers and who meets as least one of four criteria...." (RCW 71.24.025(18)) ● Seriously disturbed children, defined as: "a child diagnosed by a mental health professional...as experiencing a mental disorder which is clearly interfering with the child's functioning in family or school or with peers or is clearly interfering with the child's personality development and learning. (RCW 71.24.025 (17)(e))

Children's Mental Health Study

Agency	Laws & Agency Rules	Services Provided	Mental Illnesses/Behavioral Issues Covered
Mental Health Division, continued.	<p>Chapter 71.24 RCW: Community Mental Health Services Act</p> <p>WAC 388-865: Community Mental Health and Involuntary Treatment Programs</p>	<ul style="list-style-type: none"> ● Community support services, including (among others): <ul style="list-style-type: none"> - assessment - diagnosis - emergency crisis intervention 24/7 - case management - psychiatric treatment including medication supervision - counseling - psychotherapy <p>(RCW 71.24.025 (7), implemented by WAC 388-865-0229/0230/0235 as listed, above)</p>	<ul style="list-style-type: none"> ● Acutely mentally ill children ● Severely emotionally disturbed children <p>Both as discovered under EPSDT screening. See definitions, above.</p>
RSNs	<p>Chapter 71.24 RCW: Community Mental Health Services Act</p> <p>WAC 388-865: Community Mental Health and Involuntary Treatment Programs</p>	<ul style="list-style-type: none"> ● See all services described for the Mental Health Division, above. <p>RSNs also provide:</p> <ul style="list-style-type: none"> ● Administration of the involuntary treatment program (WAC 388-865-0245) 	<ul style="list-style-type: none"> ● See all illnesses/issues covered by the Mental Health Division, above. ● Regarding administration of the involuntary treatment program: The RSNs are responsible for designating mental health professionals to perform the duties of involuntary investigation and detention in accordance with the requirements of Chapter 71.05 and 71.34 RCW, and ensuring periodic evaluation of each committed consumer for release from or continuation of an involuntary treatment order.

Children's Mental Health Study

Agency	Laws & Agency Rules	Services Provided	Mental Illnesses/Behavioral Issues Covered
<p>Juvenile Rehabilitation Administration (JRA)</p>	<p>Chapter 13.40 RCW: Juvenile Justice Act of 1977</p>	<ul style="list-style-type: none"> ● Community-Based Rehabilitation including (among others): <ul style="list-style-type: none"> - counseling - outpatient mental health programs - anger management classes (RCW 13.40.020) ● Comprehensive diagnostic evaluation at intake, including evaluation for (among others) <ul style="list-style-type: none"> - attention deficit disorder - mental health (RCW 13.40.460(5)) 	<ul style="list-style-type: none"> ● Juvenile offenders.
<p>Children's Administration (CA)</p>	<p>Chapter 13.32A RCW Family Reconciliation Act</p> <p>This chapter is incorporated by reference into Chapter 74.13 RCW, below. WAC rules are described as related to 74.13.</p>	<ul style="list-style-type: none"> ● Family reconciliation services, including : <ul style="list-style-type: none"> - psychological treatment - mental health treatment - drug or alcohol treatment 	<ul style="list-style-type: none"> ● Children who are "at risk," meaning a juvenile who: <ul style="list-style-type: none"> - Is absent from home for at least seventy-two consecutive hours without consent of his or her parent; - Is beyond the control of his or her parent such that the child's behavior endangers the health, safety, or welfare of the child or any other person; or - Has a substance abuse problem for which there is no pending criminal charges related to the substance abuse.

Children's Mental Health Study

Agency	Laws & Agency Rules	Services Provided	Mental Illnesses/Behavioral Issues Covered
<p>Children's Administration, Continued.</p>	<p>Chapter 74.13 RCW Child Welfare Services</p> <p>WAC 388-25 Child Welfare Services – Foster Care</p> <p>WAC 388-32 Child Welfare Services to Prevent Out-of-Home Placement and Achieve Family Reconciliation</p>	<ul style="list-style-type: none"> • Behavior rehabilitation (WAC 388-25-0010/30) • EPSDT (WAC 388-25-0090) • Foster care psychological evaluation and report; treatment and report (WAC 388-25-0170(2)(i);l) • Family reconciliation services, as per RCW 13.32A (RCW 74.13.036): <ul style="list-style-type: none"> - Suicide prevention - Psychiatric care - Psychological services (WAC 388-32-0030) • In-home counseling (WAC 388-32-0015) 	<ul style="list-style-type: none"> • See 13.32A, above.
	<p>Chapter 74.14A RCW: Children and Family Services</p>	<ul style="list-style-type: none"> • Comprehensive, preventive, and early intervention social and health services (RCW 74.14A.020(5)) • Coordinated social and health services (RCW 74.14A. 020(8)) 	<ul style="list-style-type: none"> • Emotionally disturbed children • Mentally ill children <p>(Neither is defined in this statute.)</p>

Children's Mental Health Study

Agency	Laws & Agency Rules	Services Provided	Mental Illnesses/Behavioral Issues Covered
Children's Administration, Continued.	Chapter 74.14B RCW: Children's Services	<ul style="list-style-type: none"> • Therapeutic daycare and day treatment (RCW 74.14B.040) • Child abuse and neglect-Counseling referrals (RCW 74.14B.050) 	<ul style="list-style-type: none"> • Abused or neglected children who meet program eligibility criteria. (These terms are not defined in the statute, and no reference is made to any other statute.)
	Chapter 74.14C RCW: Family Preservation Services	<ul style="list-style-type: none"> • Focus child welfare services on protecting the child, strengthening families and providing necessary services in the family setting, while drawing upon the strengths of the family. 	N/A
	Chapter 74.15 RCW: Care of Children, Expectant Mothers, Developmentally Disabled WAC 388.148: Licensing Requirements for Child Foster Homes, Staffed Residential Homes, Group Care Programs/Facilities, and Agencies.	<ul style="list-style-type: none"> • Investigate any person, including relatives by blood or marriage except for parents, for character, suitability, and competence in the care and treatment of children (RCW 74.15.030(3)) • On reports of alleged child abuse and neglect, investigate agencies in accordance with Chapter 26.44 RCW, incl. child daycare centers and family daycare homes (RCW 74.15.030 (4)) 	N/A

Children’s Mental Health Study

Agency	Laws & Agency Rules	Services Provided	Mental Illnesses/Behavioral Issues Covered
Medical Assistance Administration (MAA)	<p>Chapter 74.09 RCW Medical Care</p> <p>WAC 388-500 Medical Assistance</p> <p>WAC 388-501 Administration of Medical Programs –General</p> <p>WAC 388-529 Scope of Medical Services</p> <p>WAC 388-534 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</p>	<ul style="list-style-type: none"> • Medical services outlined in WAC 388-529-0200 include: <ul style="list-style-type: none"> - Community mental health centers - EPSDT 	<ul style="list-style-type: none"> • Mental illness • Drug addiction • Alcoholism
	<p>Chapter 71.24 RCW: Community Mental Health Services Act</p> <p>WAC 388-865: Community Mental Health and Involuntary Treatment Programs</p>	<ul style="list-style-type: none"> • Community support services, including <ul style="list-style-type: none"> - Psychiatric treatment including medication supervision - Prescreening for placement in nursing homes - Screening for admission to residential services See services described for the Mental Health Division, above. 	<ul style="list-style-type: none"> • See Mental Health Division, above, for the statutory description of illnesses/issues addressed.
	<p>Chapter 71.34 RCW: Mental Health Services for Minors</p> <p>WAC 388-865: Community Mental Health and Involuntary Treatment Programs</p>	Not a law defining service.	N/A

Children’s Mental Health Study

Agency	Laws & Agency Rules	Services Provided	Mental Illnesses/Behavioral Issues Covered
Division of Developmental Disabilities (DDD)	<p>Chapter 71A RCW: Developmental Disabilities</p> <p>Chapter 388-825 WAC: Division of Developmental Disabilities Services Rules</p>	<ul style="list-style-type: none"> • Family counseling; health services and equipment; therapy services and equipment, among others (RCW 71A.12.040) • Therapeutic services not covered by another resource such as Medicaid or the public schools, including: <ul style="list-style-type: none"> - Behavior management therapy - Counseling relating to a disability (WAC 388-825-252(2)(d)) - Parent/family counseling dealing with a diagnosis, grief and loss issues, ...and behavior management (WAC 388-825-252(3)(f)) 	<ul style="list-style-type: none"> • A child with a developmental disability as defined in WAC 388-825-030.
	<p>Chapter 74.13 RCW Child Welfare Services</p> <p>Chapter WAC 388-25, Child Welfare Services – Foster Care</p> <p>WAC 388-32 Child Welfare Services to Prevent Out-of-Home Placement and Achieve Family Reconciliation</p>	<ul style="list-style-type: none"> • Out-of-Home care under voluntary placement 	<ul style="list-style-type: none"> • See 13.32A under Children's Administration, above.

Children's Mental Health Study

Agency	Laws & Agency Rules	Services Provided	Mental Illnesses/Behavioral Issues Covered
Division of Alcohol and Substance Abuse (DASA)	<p>Chapter 70.96A RCW: Treatment for Alcoholism, Intoxication, and Drug Addiction</p> <p>WAC 388-810: Administration of County Chemical Dependency Prevention, Treatment, and Support Program</p>	<ul style="list-style-type: none"> ● Detoxification ● Residential treatment ● Outpatient treatment 	<ul style="list-style-type: none"> ● Minors who have a chemical dependency, including alcoholism, drug addiction, dependence on alcohol or one or more other psychoactive chemicals.
Office of the Superintendent of Public Instruction (OSPI)	<p>Chapter 28A.155 RCW: Special Education</p> <p>WAC 392-172</p>	<ul style="list-style-type: none"> ● An eligible child is provided special education and related services designed to address their unique educational needs, in a continuum of settings. ● "Special education" includes <ul style="list-style-type: none"> - behavioral intervention instruction (WAC 392-172-045) ● "Related services" include <ul style="list-style-type: none"> - counseling services - psychological services - social work services (WAC 392-172-055) 	<ul style="list-style-type: none"> ● Emotional/behavioral disability: <ul style="list-style-type: none"> - Inability to learn that cannot be explained by intellectual, sensory, or health factors - Inability to build or maintain satisfactory interpersonal relationships with peers and teachers - Inappropriate types of behavior or feelings under normal circumstances - General pervasive mood of unhappiness or depression - Tendency to develop physical symptoms or fears associated with personal or school problems - Schizophrenia <p>(WAC 392-172-118)</p>

Children’s Mental Health Study

Agency	Laws & Agency Rules	Services Provided	Mental Illnesses/Behavioral Issues Covered
Department of Community, Trade and Economic Development (CTED)	Chapter 28A.215 RCW: Early Childhood, Preschools, and Before-and-After School Care	ECEAP: <ul style="list-style-type: none"> • Play-based learning experiences and culturally relevant materials addressing mental health, among other things. • Children are given assistance with educational, social, health, cultural, and nutritional development. • Assessment and treatment are provided through EPSDT, a component of the Medicaid program. 	<ul style="list-style-type: none"> • Children are evaluated for: <ul style="list-style-type: none"> - Behavioral disorders - Atypical behavior - Child abuse
	Chapter 74.14A RCW WAC 365-170 State Funding for Local Early Childhood Education and Assistance Programs	The Act lays out Family Policy Initiatives that the Department must follow in implementing ECEAP. It does not discuss mental health or mental health-related services.	N/A

Children's Mental Health Study

Agency	Laws & Agency Rules	Services Provided	Mental Illnesses/Behavioral Issues Covered
Agency for Children and Families, U.S. Department of Health and Human Services, Region X (ACF)	42 USC 9831- 9843a (P.L. 97-35) (45 CFR 1301-1308)	<ul style="list-style-type: none"> ● A comprehensive health and developmental history, including a physical and mental health assessment. ● Allowable services include mental health (45 CFR part 1304 (B,C,D)). ● Assessment and treatment are provided through EPSDT (see above). ● Treatment services are covered whenever they are medically necessary to correct or improve mental illness discovered through an EPSDT screening. 	<ul style="list-style-type: none"> ● Mental illness

APPENDIX 4 – INVENTORY OF PUBLIC MENTAL HEALTH SERVICES FOR CHILDREN

– Prepared For JLARC By Clegg And Associates

BACKGROUND

The 1991 Legislature mandated (RCW 71.36) that the Office of Financial Management (OFM) maintain an inventory of the array of publicly funded children’s mental health services available in Washington State. This inventory was to look broadly at all publicly funded children’s mental health services, including those provided through the education, juvenile justice, child welfare, drug and alcohol, developmental disabilities, healthcare, and mental health systems. The purpose of the inventory was to assist the state in developing a coordinated system of mental health care for children and youth.

The 2001-03 Biennial Budget directs the Joint Legislative and Audit Review Committee (JLARC) to conduct a limited study of publicly funded children’s mental health services in Washington State. A limited survey of mental health services for children was added when it was determined that the 1991 directive to maintain an inventory of children’s mental health services had not been carried out.

In particular, policymakers were interested in knowing the extent to which there are similarities and differences in the availability and structure of publicly funded children’s mental health services throughout the state. The statewide systems surveyed included those providing children’s mental health services through the Department of Social and Health Services (DSHS), the Office of the Superintendent of Public Instruction (OSPI), the Department of Community, Trade and Economic Development (CTED), and the federal Department of Health and Human Services (HHS).

FINDINGS

The completion of the inventory, including the analysis of the involved data systems, led to the following findings:

1. The statewide systems that provide children’s mental health services do not use a common definition for these services. In order to create an accurate inventory, Clegg and Associates worked with JLARC to develop a common definition. The resulting inventory revealed that nine statewide systems provide a variety of mental health services for children.
2. The array of children’s mental health services is basically the same throughout the state. There are some exceptions in the availability of particular services, e.g., day treatment is not part of the array of publicly funded children’s mental health services in all geographic areas of the state. In addition, the use of treatment methods varies, including the use of specialized treatments for specific population groups.

3. Each system providing mental health services for children has a set of eligibility criteria in place. Depending on the system, these criteria focus on clinical issues, financial qualifications, geographic specifications, participation in a specific program, or a combination of these factors. For example:
 - Eligibility for mental health services within the MHD/RSN system has several components: all persons within an RSN's boundaries are eligible for crisis services, while eligibility for other services is based on each RSN's medical necessity criteria. In addition, Medicaid-eligible children are the RSNs' top priority for medically necessary services.
 - Eligibility for mental health services through other DSHS programs and the educational system is linked to a combination of participation in a particular program, level of need, and financial eligibility. These systems often refer children who meet the MHD/RSN eligibility criteria to the mental health system for services.
4. There is no uniformity in data systems among the statewide systems that provide mental health services for children. Further, several of the systems surveyed do not use a database to record the mental health services they provide. This combined lack of consistency and capacity poses several major challenges in completing a more detailed inventory, including:
 - It is not possible to develop a statewide, unduplicated count of all of the children who received mental health services through the public systems that provided these services (DSHS, OSPI, CTED, HHS).
 - It is not currently possible to identify a statewide, unduplicated count of the children who received mental health services through DSHS due to the lack of data reporting capacity by the Juvenile Rehabilitation Administration. DSHS can identify unduplicated counts of children who were served by the other DSHS administrations/divisions, and can identify the number of children who received services from multiple systems.
 - The current consolidated DSHS database allows for statewide, but not regional or countywide comparisons of service delivery across administrations/divisions. Geographic breakouts using the consolidated database do not accurately reflect service delivery in a particular geographic area because clients are located by their most recent address, which often places them in a different geographic area than the one in which they received services.
 - There is no state-level aggregation of mental health service data within the education system. Individual schools and local school districts decide whether and which mental health services to provide and do not report these services above the school district level, if at all. This lack of data prevents the analysis of service availability across the state and the use of information relevant for service coordination purposes, such as the

proportion of children concurrently receiving mental health services through both the mental health system and the educational system.

- The Early Childhood Education and Assistance Program (ECEAP), administered by CTED, does not track the children's mental health services it provides. Head Start, implemented through HHS, does track the mental health services provided through its program. However, there is no common client identifier that would allow identification of Head Start children who also received mental health services through other state programs.
- It is possible to produce accurate counts of the number of children who received services from each of the Mental Health Division's (MHD) Regional Support Networks (RSNs). The MHD can also identify the unduplicated number of children who received mental health services throughout the state.

The implications of the challenges encountered during the creation of this inventory, particularly those related to the provision of children's mental health services by multiple statewide systems and the lack of a coordinated approach to defining and tracking services, point to additional underlying issues of importance, including:

- The degree to which children throughout the state have access to the available array of mental health services. A child's ability to access services depends on a number of factors, including the financial and clinical eligibility criteria that govern utilization of services, where the services are located in relation to where the child lives, and the capacity of the mental health agencies to provide services for the number of children who are eligible.
- The intensity or amount of services each individual received. While the inventory describes which services are available and estimates (to the extent the information is available) how many children received each of these services, it does not address the amount (or intensity) of services each child obtained. An understanding of service intensity would allow for a more in-depth analysis of the functioning of the system.
- The cost-effectiveness of the services. The cost data collected for the inventory provides a very limited amount of information on the sources and levels of public funds that are currently supporting children's mental health services. The inventory does not address the relationship between the cost of these services and the outcomes they are producing.
- The quality of services. The development of an understanding of the quality of services provided through the children's mental health system requires a type and level of data collection and analysis not included in the inventory.

CONCLUSIONS

A number of the steps that were required to complete a limited inventory for this study offer practical tools for the state's multiple systems to improve the coordination of their services. Most notably, the completion of the inventory required the creation of a common definition of children's mental health services that was consistent with statutory intent and understandable to the multiple systems across the state that provide these services. The development of this common definition, and its future use, can improve the multi-system coordination efforts mandated by the Legislature.

In addition, the future standardization of some of the DSHS data fields would allow for easier development of more accurate estimates of the number of children who received each of the services, regardless of which administration/division within DSHS provided the service. This would assist in the identification of children served in common by multiple systems. The ongoing availability of this information could be of value in the coordination efforts of the DSHS programs that provide mental health (and other services) to the same children.

APPENDIX 5 – PERFORMANCE DATA INDICATORS AND OUTCOMES MEASUREMENT FOR MENTAL HEALTH SYSTEMS FOR CHILDREN

BACKGROUND

Dougherty Management Associates, Inc. (DMA) was retained by the state of Washington's Joint Legislative Audit and Review Committee (JLARC) to conduct a review of performance indicators and outcomes measurement for mental health systems for children as part of the Children's Mental Health Study. DMA, a research and consulting firm in Lexington, Massachusetts, has extensive experience working with state and county health and human service organizations. DMA's work involves strategic planning, procurement consulting, and conducting national research on quality and cost-effectiveness in publicly funded systems. One current national project is gathering, comparing, and disseminating indicators on financial, utilization, and quality performance of children's public mental health systems throughout the country.

For JLARC, DMA has reviewed performance and outcomes measurement systems to provide models for Washington and has assessed the current data and reporting by the Washington State Department of Social and Health Services (DSHS), Mental Health Division (MHD), Regional Support Networks (RSNs), and providers to determine its adequacy for use in performance and outcomes measurement. In addition, DMA reviewed the measurement framework laid out in the December 13, 2000, JLARC Performance Audit of the Mental Health System and developed recommended modifications to this framework. DMA's recommended modifications are aimed at assisting stakeholders to improve Washington's performance and outcomes measurement system so that it ultimately allows reporting of data to the Legislature that can inform their decision-making. In addition, the recommendations seek to provide information to MHD on ways to make the data more useful for their decision-making as well as to increase the comparability of data to allow comparisons among RSNs and comparisons with other states.

FINDINGS

The findings below result from DMA's review of not only the collection and reporting of data within Washington State but also initiatives outside the state. Reviewing other initiatives enables states and counties to better understand and assess their own systems. In addition, availability of data can assist stakeholders to evaluate the children's mental health system and also is likely to prompt valuable quality improvement efforts.

Review of Statewide and National Initiatives

Successful implementation of performance and outcomes measurement systems requires state agency resources as well as buy-in from state leadership.

Systems utilize data in a variety of ways including legislative reporting, quality improvement, performance incentives, and for clinical tools and provider practice profiles. Of the systems reviewed, one state currently utilizes financial incentives.

MHD Statewide Measurement and Reporting

MHD does not currently report expenditure or cost data by age. Therefore, critical cost indicators such as cost per individual served or cost per unit cannot be reported separately for children. (MHD reports they can calculate RSN direct expenditures per individual served and per unit for broad service categories such as crisis, residential, and inpatient; they just cannot report children and adults separately.)

MHD currently collects individual point-in-time data such as current living situation. MHD does not yet have the algorithms in place to report individual change scores although MHD reports they are working on implementing the programming that will allow for tracking change at the individual client level. This is an area where MHD is obtaining technical assistance to implement the tracking system.

MHD has made progress by improving the data requirements and data specifications in response to the December 2000 JLARC Report. Many RSN representatives and providers believe additional improvements must be made to permit data comparisons across the state.

RSN Measurement and Reporting

RSNs vary in sophistication and in type of outcomes measurement used for children; some collect data on numerous measures while others do not monitor or require any clinical outcomes data from the providers.

RSNs are expecting leadership and guidance from MHD regarding clinical outcome measures. Specifically, a number of RSNs report they have not yet implemented clinical outcome measures because they are 'waiting on the state' to require specific measures.

Administration of the Child Global Assessment Scale (CGAS) instrument appears inconsistent across RSNs. Some RSNs are not administering the CGAS even though results are a required element in the revised MHD data dictionary, effective January 1, 2002.

RECOMMENDED APPROACHES TO DEVELOP OUTCOMES FOR CHILDREN

One of the goals of the DMA recommendations listed below is to help Washington develop a successful performance and outcomes measurement project. Such a project

will enable the Legislature, MHD, RSNs and providers to monitor performance by using data to identify trends and make comparisons with like organizations. Implementing any performance and outcomes measurement system entails challenges; however, other initiatives demonstrate that the likelihood of success is far higher in systems with regular stakeholder collaboration and in those that embrace continuous quality improvement. Implementation of these general recommendations should lead to an improved performance and outcomes measurement system with an increased level of data comparability and reliability.

1. Core Set of Measures:

Begin by collecting and monitoring a core set of measures from the Measurement Framework in the December 2000 JLARC Report.

Rationale

A core measurement set will reduce provider burden and give stakeholders a focused way to monitor system performance. The current framework properly reflects many of the data collection recommendations that national initiatives have made; however, it should be reduced in size to provide a more focused set of measures for Washington's children's mental health system. Beginning with a core data set will also allow MHD, the RSNs, and providers to identify areas where data need improving and to work together to increase data reliability and validity. In the future, MHD may want to include additional measures from the Framework or other 'developmental' measures as the need arises to monitor other areas of the children's mental health system.

2. Regular Distribution of Outcome Data:

Encourage MHD to distribute statewide and RSN comparison data in a regular and timely way.

Rationale

Regular feedback should increase provider reporting and accuracy. Other systems implementing performance and outcomes measurement systems have found that distributing and publishing data regularly, even without actual consequences, can increase compliance with data reporting merely by creating a 'peer pressure' effect. Organizations do not want to be singled out among their peers for being non-compliant or error prone in data reporting. Regular reporting also can reduce organizations' sensitivity to being measured by making the practice commonplace. MHD should work on creating standards for frequency of the reporting of specific measures. Depending on the measure, reporting may be monthly, quarterly, or annually. For example, cost measures may only be reasonable to report annually, while measures such as penetration can and should be reported more frequently.

3. Data Specificity:

Continue to increase the level of specificity for data definitions.

Rationale

Detailed data specifications should increase data consistency and comparability. MHD has been working with a performance improvement workgroup to define the measures currently being reported; however, many performance measurement initiatives have found that multiple iterations are necessary to ensure that data can be compared across regions within a state or across states.

4. Data Collection Training and Reporting:

Provide training to RSNs and providers in data collection and reporting.

Rationale

Training, coupled with increased definitional specificity, will increase data reliability and data quality. Training can reduce some differing interpretations among those individuals collecting and reporting the data.

5. Link System Goals with Measures:

Link desired system goals more directly to measures.

Rationale

System goals help to provide clearer expectations and a rationale for data use. Providers and other stakeholders may become more invested in the performance measurement program if the goals are clearly understood. In addition, financial incentives for reporting might be considered to encourage RSN reporting.

6. Separate Child and Adult Costs:

Collect and analyze data to separate child and adolescent costs from adult costs. This will permit MHD to track RSN direct service expenditures per child served and per unit of service for children served.

Rationale

Because expenditure data provide an indication of the level of resources used by the mental health service system, they are central to any public reporting system. Understanding the reasons for differences in spending per client and the types of services funded will be enormously useful for the policy debates on new initiatives or policy changes.

Review of Performance Data

Indicators and Outcomes Measurement for Mental Health Systems for Children

Framework of Performance And Outcomes Measures Specific to Children

Access:

1. Penetration rate
2. Utilization rate for specific service types
3. Consumer/family perception of access

Quality/Appropriateness:

4. Consumer/family perception of quality/appropriateness
5. Consumer/family perception of participation in decision-making
6. Follow-up after hospital discharge within 7 days
7. 30-day readmission rate

Outcomes:

8. Consumer change as a result of services
9. Living situation or community tenure
10. Juvenile justice involvement rate
11. Substance abuse services rate

Structure/Plan Management (Financial):

12. RSN service expenditures per child served
13. RSN service expenditures per unit of service (for specific service types)

Dougherty Management Associates, Inc.

The recommended measures are a sub-set of the JLARC Framework Measures and what DMA considers a 'core' set. We excluded some Framework measures from the core set because there was no current data source, the measure was not directly relevant to children, or the measure would be overly burdensome to collect. Implementation of a core measurement set will reduce provider burden in the short-term and give stakeholders a focused way to monitor system performance. Once the core set is established, if the need arises to monitor other areas of the children's mental health system, MHD may want to consider adding measures.

CONCLUSION

In order to make informed budget and policy decisions, during this period of scarce resources for public mental health services, purchasers need data on the impact of services on consumers as well as the overall system performance. Increasingly, public

mental health systems are finding it useful and necessary to systematically collect and report measurement data that can be benchmarked with other systems. Collecting, analyzing, and benchmarking performance and outcomes data within public mental health systems serving children can enable stakeholders to identify areas for improvement and thus ultimately lead to improved quality and accountability.

In recent years, Washington State has made good progress toward implementing a performance measurement program for the public mental health system. However, as the findings indicate, stakeholders in Washington need to implement new or refocused efforts, such as those outlined in this report's recommendations, aimed at developing a consistent and comparable performance and outcomes management system to ensure data are valid, reliable, and useful for decision-making. In addition, public reporting of data also needs to become more frequent, systematic, and widely distributed. Investment in properly implementing performance and outcomes measures that are common to those used by other systems should provide a corresponding 'return on investment' in the form of trend data that will enable effective oversight while providing reasonable comparisons between RSNs and between Washington and other states.

