

CHAPTER 2

A System of Tunnels and Cliffs

PURPOSE

This chapter describes

- the “tunnel problem” in systems serving youth,
- an ideal scenario for accessing services,
- treatment interventions for youth with mental health needs, and
- the “transition cliff” between youth and adult systems.

Ross and Miller describe the “the tunnel problem” in systems serving youth as follows:

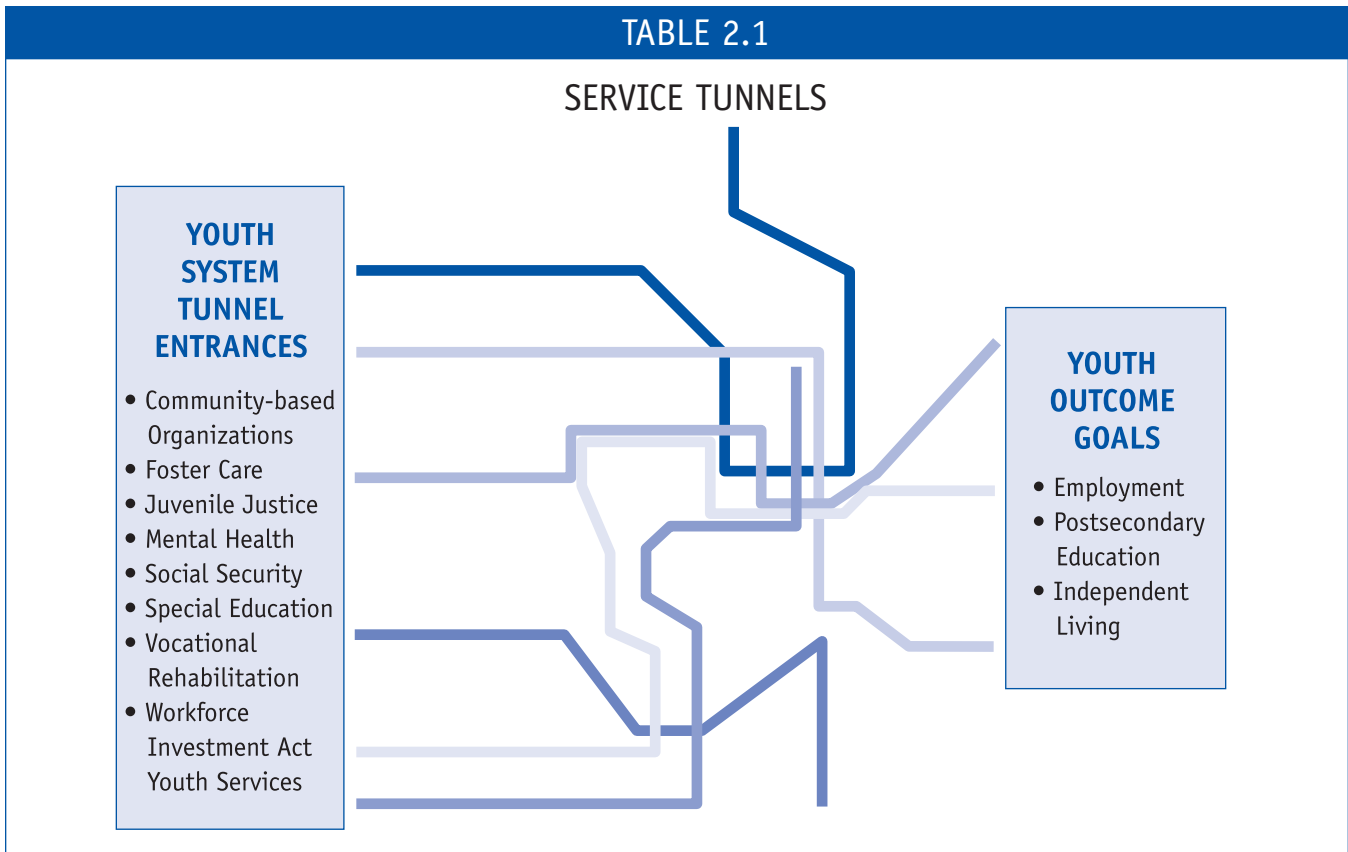
Each of the many systems that serve youth has a fixed menu of services or solutions to offer. Because most agency staff members think primarily of the set of solutions within their system, they usually send youth down one of these “service tunnels.” The tunnel may be the most appropriate choice among the agency’s set of options, but may still be an ineffective course of action. Once a youth starts down a particular tunnel, it is often hard to reverse course and take a different path (2005, p. 4).

Any discussion of the services that youth receive would be incomplete without highlighting that issues of cultural competence and institutional racism are rife in this field. Youth of color, especially African Americans, are more likely to receive harsher treatment when involved in school discipline proceedings, child welfare cases, or the juvenile justice system... Tunneling, then, is not only a function of a youth’s problem, but is also influenced by conscious and unconscious biases on the part of government agencies (2005, p. 5).

The service tunnels or systems that may serve youth include community-based organizations, foster care, juvenile justice, mental health, Social Security, special education, vocational rehabilitation, youth services funded by the Workforce Investment Act, and others. Table 2.1 illustrates the overlapping and confusing nature of the service tunnels that may serve youth with MHN.

Eligibility requirements for accessing services vary across these systems and range from mandatory services (public schools) to criteria based on factors such as income, severity of a disability, ability to benefit, and family circumstances. Each system has its own terminology, which, as noted previously, may be particularly confusing in the case of youth with mental health needs.

TABLE 2.1



For youth service practitioners in a service tunnel, understanding another service system and how to access its services may be overwhelming. Not only is the terminology used to describe mental health needs and services unfamiliar, but the concept of a mental health system itself is dynamic and can vary significantly between communities. Consequently, youth service practitioners in one tunnel, such as a Workforce Investment Act youth program, may need to follow different protocols from a similar program in another area to access mental health services for youth. However, there are some similarities in services between and among states that receive federal funds for mental health services.

States that receive federal funds as part of the Mental Health Block Grant program, awarded by the Center for Mental Health Services, must provide comprehensive community-based systems of care for adults with serious mental illnesses and children with serious emotional disturbances. This approach, often referred to as Systems of Care (SOC), builds (1) partnerships to create a broad, integrated process for meeting the physical, mental, social, emotional, educational, and developmental needs of children in the child welfare

systems, and (2) the infrastructure needed to result in positive outcomes for children and families. The SOC philosophy, as described by the National Clearinghouse on Child Abuse and Neglect Information, is based on principles of interagency collaboration; individualized, strengths-based care practices; cultural and linguistic competence; community-based services; and full participation of families, including youth, at all levels of the system.

Youth up to the ages of 18 or 22, depending on the program, may enter the child/youth mental health system. Table 2.2 describes an ideal scenario for a youth accessing services because of a critical incident requiring intervention from outside the family. This ideal has yet to be achieved, since mental health services for adults and youth differ considerably across states and localities due to variations in available resources and community needs.

At each step of the process, a number of different service providers and others providing natural supports, as well as youth and family, are involved in key decision points that affect the next steps and ultimately access to effective treatment to address the critical incident.

TABLE 2.2

An Ideal Scenario for a Youth's Initial Point of Entry into Mental Health Services

A youth has an incident that is typically identified by an adult within one of the major youth serving or law enforcement agencies (or by a parent) as a significant concern warranting external support.

Diagnostic Formulation

Depending on the nature of the event, one or more diagnostic activities are conducted.



Determination of Eligibility

Youth and family are evaluated to determine the adequacy of financial resources needed to support the treatment plan. Case management should be implemented here or at the interagency coordination stage and should continue through follow-up and monitoring.



Interagency Coordination

Agencies, youth, and families convene to discuss support for eligible youth with agency partners determining their respective level of support for treatment.



Treatment Plan

A treatment plan is developed based on the diagnostic impressions and on input from the youth and family.



Treatment Implementation

Treatment services such as home and/or community support (preferred); individual, group, and/or family therapy; special education; medication; or residential treatment are implemented.



Follow-up/Monitoring

This process keeps track of treatment progress and ensures a measure of quality control.



Aftercare Services and Supports

This process provides supports and service to youth after treatment is completed, if necessary, to ensure that the youth sustains progress.

TREATMENT INTERVENTIONS

It should be noted initially that youth with mild to moderate mental health needs may need minimal or no supports. There are, however, several effective treatment options open to those youth with MHN who do access treatment. This section provides a brief overview of the mental health services that youth may access as part of their treatment plans. The descriptions are not intended to imply a perspective on treatment effectiveness or to cover the multiple aspects of the treatment modalities, but instead to orient youth service professionals to the organization of treatment services for youth.

Home-Based Services. The major goal of home-based services is to maintain the youth at home and prevent an out-of-home placement (i.e., in foster care or in residential or inpatient treatment). Home-based services are usually provided through the child welfare, juvenile justice, or mental health systems. Home-based services are also referred to as in-home services, family preservation services, family-centered services, family-based services, or intensive family services. The services are tailored to the individual needs of families.

Community-Based Interventions. Since the 1980s, community-based interventions have become more widespread within the youth mental health treatment continuum. These interventions seek to provide a range (mild to intensive) of clinical and social supports to create a network of services for youth and families within their community. Community-based interventions may include services such as case management, home-based services, respite services, wraparound approaches, therapeutic foster care, therapeutic group homes, and crisis services.

School-Based Mental Health Services. School-based treatment and support interventions are designed to identify emotional disturbances and to assist parents, teachers, and counselors in developing comprehensive strategies for addressing these disturbances. School-based services may include wraparound services such as counseling or other school-based programs for emotionally disturbed children, adolescents, and their families within the school, home, and community environment. For example, "community schools" have

partnerships between the school and other community resources, with an integrated focus on academics, services, and supports (such as in-school mental health services) that ultimately lead to improved student learning, stronger families, and healthier communities. (More information on community schools is available from the Coalition for Community Schools at <<http://www.communityschools.org>>.)

Outpatient Treatment and Intensive Outpatient Treatment. This is one of the most common types of mental health treatment and simply refers to the mode of service delivery in which the youth and family visit an office for treatment while living in a home environment. This intervention covers a large variety of therapeutic approaches, with most falling into the broad theoretical categories of cognitive, interpersonal, and behavioral psychotherapy.

Medication Treatment. Medication treatment refers to the use of drugs to treat a range of emotional, behavioral, and mental disorders in children. Mental health experts recommend the following: (1) A comprehensive evaluation by a qualified mental health professional with expertise in diagnosing and treating children and youth should be conducted prior to initiating treatment; and (2) This treatment should be part of an integrated and comprehensive treatment plan (which might include behavior management techniques or behavioral rehabilitation services) developed cooperatively with the youth and family.

Partial Hospitalization and Day Treatment. Partial hospitalization is a specialized and intensive form of treatment that is less restrictive than inpatient care but is more intensive than the usual types of outpatient care (i.e., individual, family, or group treatment). The most common type of partial hospitalization is an integrated program combining education, counseling, and family interventions. The setting may be a hospital, school, or clinic and may be tied to the type of treatment recommended for the youth. Partial hospitalization has also been used as a transitional service after either psychiatric hospitalization or residential treatment at the point when the youth no longer needs 24-hour care but is not ready to be integrated into the school system or community. It may also be used to prevent inpatient placement.

Residential Treatment Centers. Residential treatment centers (RTCs) are the second most restrictive form of care (next to inpatient hospitalization) for youth with severe mental disorders. A residential treatment center is a licensed 24-hour facility (although not licensed as a hospital), which offers mental health treatment. The period of treatment at RTCs can range from brief placements of a few weeks to longer-term treatment of several months. The type of treatment provided at an RTC can vary greatly. The more common treatments include individual psychotherapy, psychoeducation (e.g., educating the youth and family about his or her MHN and about treatment options), behavioral management, group therapies, medication management, and peer-cultural therapies. Settings for RTCs can range from formal or structured environments that resemble psychiatric hospitals to those that are more like group homes or halfway houses.

Inpatient Treatment. Inpatient treatment (or hospitalization) is the most restrictive and expensive type of care in the continuum of mental health services for children and adolescents. Inpatient treatment typically refers to clinical care provided on a 24-hour basis in a hospital setting.

Case Management. Case management is an important and widespread component of mental health services, especially for children with serious emotional disturbances. The main purpose of case management is to coordinate the provision of services for individual children and their families who require services from multiple service providers. Case managers take on roles ranging from brokering services to linking with and advocating for services that families need. There is a considerable amount of variation in case management models. In the wraparound model, case managers involve families in a participatory process of developing an individualized plan focusing on individual and family strengths in multiple life domains.

Treatment plans and services need to be factored into a youth's career planning process as appropriate. For example, workforce development counselors, transition specialists from the public schools, vocational rehabilitation counselors, youth service provider staff, and other youth service practitioners

youth exit the school system, usually between the ages of 16 and 22, their IEPs legally do not follow them (although a quality transition plan can do much to bridge the cliff).

Mental health services for children and youth usually terminate at age 18 or 22, depending on the program. Adult mental health service options vary widely among jurisdictions and may be severely limited in rural areas. Because of high demand, eligibility is often limited to those with the greatest need, and long waiting lists for services through the mental health agency in the local health department are not unusual. Youth who do not qualify for subsidized services or who are on the waiting list will find that they must pay for expensive services such as emergency hospital care, residential and day programs, substance abuse programs, and psychiatric counseling. Even if the youth qualifies for subsidized services through the mental health agency, funds are limited, especially under state guidelines that set expenses at specified amounts based on the diagnosis and treatment options. Transportation to and from services is usually the responsibility of the youth. Medicaid and TANF may cover transportation costs for eligible youth for some mental health services from qualified providers.

A number of services may be provided to youth under WIA. Services under WIA Title I for youth ages 14 to 21 are delivered via service providers whose programs have been approved by the local Workforce Investment Board (WIB) to prepare youth for the needs of the local labor market. Eligibility requirements are based on income and on the existence of barriers to employment such as disabilities. Youth activities may include tutoring and study skills training, GED programs, summer employment opportunities, paid and unpaid work experiences, occupational skills training, leadership development opportunities, supportive services, adult mentoring, follow-up services, and guidance and counseling services. Youth activities and programs are provided at the youth provider's location, which may be in public schools, on job sites, at community colleges, or at adult education or GED locations. Youth who are 18 or older may qualify for both youth and adult services. The goal is for youth to leave the youth programs with one or more of the following achievements: (1) significant gains in literacy and numeracy, (2) attainment of a degree or certificate,

or (3) placement in employment, advanced training, or education.

WIA Title I also includes Job Corps, a federally administered program providing academic and occupational training in a residential setting to youth ages 16 to 24. In addition to age limits, eligibility requirements are also based on income and barriers, and the upper age limits may be waived for eligible youth with disabilities.

Adult literacy programs funded under WIA Title II provide basic education instruction in a variety of program settings to individuals over the age of 16 who are not currently enrolled in school and who lack a high school diploma or the basic skills to function effectively in the workplace.

WIA Title IV incorporates the Rehabilitation Act of 1973, which funds state rehabilitation agencies, supported employment services, and independent living centers. State rehabilitation agencies provide employment preparation services to individuals who have a physical or mental impairment that results in a substantial impediment to employment, who are able to benefit from services, and who require vocational rehabilitation in order to secure employment. There are no statutory age requirements for service, which may be set by states or state regions. Supported employment provides on-going workplace supports to individuals with the most significant disabilities. These services may include recruitment, workplace training, transportation, counseling, and independent living. Age is not specified for supported employment. Independent Living Centers help people with disabilities maximize opportunities to live independently in the community. Centers can provide employment-related support, but actual training or education is not typically provided. Centers set their own age requirements.

In contrast to WIA youth programs, the goal of WIA Title I adult services is employment via the services of a One-Stop Career Center. Core services are available to all adults 21 and older and include self-directed job searches using computerized and on-site resources, career interest surveys and job-matching software, computer tutorials on topics such as preparing a resume and cover letter, and basic job search

orientations. Adults who have difficulty finding a job may qualify for “intensive services” based on income and employment barriers. Intensive services may include comprehensive and specialized assessments of skill levels and service needs, in-depth interviewing, evaluation to identify employment barriers and goals, seminars and training in job search techniques, and one-on-one counseling by One-Stop Career Center staff. Adults who are unsuccessful in finding a job after receiving intensive services may be eligible for short-term job training based on priorities established by the local Workforce Investment Board.

The transition from a system where services are provided via an Individualized Education Program in school or through a youth service provider program to an adult system with different eligibility requirements and self-directed activities can be traumatic. *This is especially true for youth with mental health needs in workforce development programs, who are less likely than*

others to disclose their disability because they wish to avoid being stigmatized or labeled. Youth with hidden disabilities may enroll and enter educational, training, and employment programs without communicating their disability and needs for accommodations and special assistance.

As discussed in Chapter 1, the nature of hidden disabilities makes identifying and accessing needed interventions and supports more difficult. Additionally, parents and youth service professionals often have an inadequate understanding of the nature of hidden disabilities or of useful accommodations. Awareness of service tunnels and the transition cliff on the part of policymakers, administrators, and youth service practitioners is the first step in creating service delivery systems that will serve youth and adults more effectively.

Please see Appendix B for the list of references.

Supporting Research

The Center for Mental Health Services has identified a number of effective, evidence-based practices for young adults and adults including the following: (1) Illness Management and Recovery, which helps people manage their mental illness by setting personal goals and developing day-to-day action strategies; (2) Customized Assertive Community Treatment, which actively involves the community in supporting people with mental illness so that they stay out of the hospital and function effectively in the local community; (3) Supported Employment that helps people find and keep competitive employment and integrates on-the-job support strategies with mental health services; (4) Family Psychoeducation, which is a partnership among consumers, families, supporters, and practitioners, in which individuals and their families learn about and discuss mental health needs and treatment options; and 5) Integrated Dual Diagnosis Treatment for people who have both mental illness and a substance abuse problem, in which treatment for both conditions is provided at the same time and in the same setting rather than in separate programs (Center for Mental Health Services, n.d.).

The SOC philosophy is based on principles of interagency collaboration; individualized, strengths-based care practices; cultural and linguistic competence; community-based services; and full participation of families, including youth, at all levels of the system (National Clearinghouse on Child Abuse and Neglect Information, 2005).

Connecting schools and transition programs with social service agencies in order to negotiate and coordinate services is termed a wraparound model (Stroul, 1993), and it emphasizes four overarching principles: (a) Services should be individualized, based on the specific needs of the youth with MHN and his or her family; (b) Services should be family-centered and involve families in all aspects of planning and treatment; (c) Services should be community-based and provided in the least restrictive environment; and (d) Services should be culturally and linguistically competent, and sensitive to cultural and ethnic values (Burns, Hoagwood, & Maultab, 1998).

The wraparound philosophy and resulting approaches differ further from the traditional service delivery system in that they (a) focus on the strengths of the individual and his or her family, (b) are driven by the needs of the individual as opposed to the needs of agencies, (c) deal with all aspects of the individual's life, and (d) provide services and support for the individual in natural settings and use social networks such as family and friends. The wraparound approach is fully

consistent with transition planning in that it requires interagency teams to be outcome oriented and to use resources in flexible and creative ways to meet the transition needs and goals of youth with MHN (Eber, 1996).

Of the 4.3 million teens who received mental health treatment in 2001, about 2 million were served by school-based health services; an equal number received specialty health services, and about 332,000 were served in residential or in-patient settings. These numbers represent only about a third of those who needed mental health services, and service use dropped as youth move into the adult world (Gralinkski-Bakker, Hauser, Billings, Allen, Lyons Jr., & Melton, 2005, p. 1).

Outpatient psychotherapy is the most common form of treatment for children and adolescents and is used annually by an estimated 5% to 10% of children and their families in the United States (Burns, Hoagwood, & Maultab, 1998). Although used by a relatively small percentage (8%) of treated youth, nearly one-fourth of the national outlay on child mental health is spent on care in residential treatment settings (Burns, Hoagwood, & Maultab, 1998).

Despite the varied and intense service needs of youth with MHN, few in this population will receive services from community-based agencies, connections that may be critical to transition success. Moreover, social and mental health services too often are offered slowly, ineffectively, and inefficiently (Burns, 1999; Burns, Hoagwood, & Maultab, 1998; Burns, Hoagwood, & Mrazek, 1999; Kutash & Rivera, 1996; Smith & Cuthino, 1997).

Collins, Schoen, Tenney, Doty, & Ho (2004) found that youth ages 19 to 29 comprise a disproportionately large share of people without health insurance. Many young people lose health coverage under their parents' insurance policies (as well as under Medicaid and the federal Children's Health Insurance Program, CHIP) when they reach the age of 19 or graduate from high school or college.

Please see Appendix B for the list of references.