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Children with severe emotional, mental, and behavioral disturbances are often referred to as children who “fall through the cracks” between the various agencies and programs that should be caring for them and for their families. Ironically, the fundamental problem of child and family mental health care in this country is that our public policy for child and family mental health has itself fallen through the cracks. Jane Knitzer’s Unclaimed Children documented this policy failure more than a decade ago: Through a survey of states, Knitzer found that multiple agencies, with fragmented responsibilities and resources, typically avoided involvement with the children most in need of mental health services. She estimated that of the three million children with the most severe disturbances, only one million were served at all, and most of those were not served appropriately.

Somehow we have backed into a policy for child and family mental health care that is, in every respect, perverse. We have artificially limited the traditional mental health benefit so that it runs out close to the time when it is most needed. This can leave a critical hiatus in care just as a child’s condition goes from bad to worse and as a family’s tolerance and strength are most vulnerable. Public funding is withheld until there is a full-blown crisis and the home situation has fallen apart. Then these resources are divided unevenly among five or six public agencies, none of which, by itself, is equipped to provide intensive care and all of which have a great incentive to shift responsibility to the other agencies.

In this Commentary we argue that a coherent public policy for child and family mental health care, shaped by the reforms of the past decade and strategically focused on integrating the efforts of all responsible parties, can guide the current transition to managed care in the states to improve the system dramatically.
Framework For A Coherent Public Policy

Four issue areas must be balanced to frame a clear policy and a practical strategy to implement it. First, a policy for child and family mental health care must be consistent with the unique requirements of children’s health. A recent Institute of Medicine (IOM) workshop on improving the quality of care for children pointed out three critical differences between health care for children and that for adults. Children, by definition, are in a period of rapid and complex developmental change, are essentially dependent on adults and community institutions (such as schools), and have patterns of illness and injury that are essentially different from those of adults. Effective health care delivery, the IOM task force found, must take these differences into account.

Second, a coherent public policy must address integration of the delivery system, because the substantive work of child and family mental health care cannot be achieved unless the efforts of all responsible agencies are combined. Treatment strategies for children must be adjusted constantly to meet the changing needs of young patients, given their unique health requirements. Families must play a pivotal role in planning, participating, and guiding schools and other community resources serving children. Finally, the delivery system must be oriented to provide flexible, spontaneous interventions to prevent or ameliorate symptoms that are not fixed in clear diagnostic patterns, in contrast to mental illness or disability in adults. This requires tightly integrated delivery systems that have command over all available resources, allowing no opportunities to shift responsibilities to other agencies. These integrated delivery systems must operate flexibly in the context of family and community life, including unique cultural contexts and venues that are not typically identified with mental health care. “Mental health is not a place,” one analyst has declared. For children with severe emotional, mental, and behavioral disorders, mental health is an accessory to every situation in which a child can grow and develop.

Third, integration of effort requires that the barriers of bureaucratic and institutional interests be overcome. Existing public and private providers and public bureaucracies have vested interests, and the problems of turf and competition among public agencies in claiming and dividing the public budget are common. This, unfortunately, creates a barrier between children and the institutions whose mission it is to help them. A coherent policy for child and family mental health care is likely to be threatening to many of these institutions.

Fourth, the changes that result from a transition to managed care provide an opportunity to activate a coherent public policy that supports the improvement of children’s mental health. The movement of public health
care purchasers such as Medicaid agencies to various forms of managed care contracting poses a danger to existing programs, some of which will be abandoned, and also provides an opportunity to bring child and family mental health care into the mainstream of the U.S. health care system. A coherent policy for child and family mental health care that is consistent with the special health care needs of children and that proposes integration of the fragmented efforts of many agencies that need to see reform in the context of their own categorical missions could provide guidance that would turn this impending change into progress. This is, of course, a tall order. But a decade of experience in a series of model programs and in planning at the state level provides reason to believe that it is possible.

### Integrated Care: A Policy Template Built On Experience

If the correction of our failed child and family mental health policy could be found in a phrase, it would be integration of effort: integration with pediatric primary care to provide the earliest possible intervention and continued collaboration between pediatric and mental health care; integration among responsible categorical agencies to eliminate the confusion of overlapping jurisdictions and the isolation that results when children fall into “cracks” between the different systems; and integration within service delivery organizations to ensure that care is matched to each child’s needs in the most efficient and effective way.

In the past decade and a half, several institutions have laid out the blueprints for a coherent policy for integrated child and family mental health and have demonstrated many features of such a policy. Throughout the 1980s the National Institute of Mental Health’s (NIMH’s) Child and Adolescent Service System Program (CASSP) helped states to articulate a model system of care that provided the broad outline of how services could be coordinated and the guiding principles for interagency efforts to serve children with severe emotional disturbances and their families.\(^4\) The Mental Health Services Program for Youth (MHSPY), a $20.4 million initiative by The Robert Wood Johnson Foundation; The Annie E. Casey Foundation’s Mental Health Initiative for Urban Children; and, now, grants for comprehensive services by the Center for Mental Health Services (CMHS) have all demonstrated the critical issues of implementation and continue to do so.\(^5\) The experiences of these efforts can be distilled into a model for a special system of care for child and family mental health with well-defined features. We propose this model as a template for a coherent policy for child and family mental health care.

This model calls for new structural relationships between public categorical agencies, both public and private payers or purchasers of care, and
providers (individuals or agencies). It requires a new way of organizing service delivery among providers in local communities. And it demands that we rethink our methods of financing and funding services, to maximize the effect of economic incentives to achieve the goals of a policy of integration.

Interagency structure. New interagency structures for integration of effort are built on new partnerships among the responsible categorical agencies—including the Medicaid agencies—in states’ central bureaucracies and among operating units of the categorical agencies at the local level. These arrangements require policy support from statutory agencies that permit local delivery systems to work together to organize and manage the full continuum of care.

In North Carolina’s MHSPY site, a state interagency advisory committee created an interagency compact that oversaw agreements among sixty-six local county categorical agencies in eleven western counties and the sovereign Eastern Band Cherokee Nation for developing integrated area programs. Kentucky’s Bluegrass Impact program developed a collaborative delivery system in seventeen counties around Lexington and Frankfort under the authority of a cabinet-level state interagency coordinating council. At the local level, the Partners Project, another MHSPY site, located in Portland, Oregon, created a consortium among five agencies, including two school districts, that pooled funds that otherwise would have been spent on a target population of children with severe disturbances. With Medicaid participation, the project created an integrated delivery system under a global, capitated rate, providing seamless, comprehensive care to children and their families.

This kind of organization does not necessarily mean replacing providers, but rather organizing them into an effective network to respond directly to the individual needs of children and their families. Generically, this kind of organization can be called a care management entity, that is, an agency that can, together with its affiliate providers and the active participation of its member families, marshal the resources to provide intensive individualized care or basic supportive services to a family. In Cincinnati, four county agencies—child welfare, mental health, developmental disabilities, and substance abuse—are pooling $7 million and forming a purchasing authority to contract with care management entities, that is, lead agencies organizing networks of providers for the care of targeted populations of high-need children and their families. In cases like this, the local delivery systems—the care management entities—act as risk-bearing, special-purpose systems of care. The role of the public agencies changes, too: They are no longer relatively passive administrators of public entitlements but aggressive purchasers, intent on obtaining value-high-quality care at reasonable cost.
Organization of service delivery. By focusing on the actual delivery systems created by multiagency consortia in these reform initiatives, it is possible to distinguish a series of components that flesh out a policy template. First, the multiagency consortium creates a clearly defined and strong governance authority that is appropriately accountable to all stakeholders. In Stark County, Ohio, the categorical agencies pooled $900,000 for a special service delivery system for an agreed-upon population of children with a high level of need and their families.

Second, service delivery is organized and overseen by a central organizational unit, or care management entity. In Dane County, Wisconsin, the nonprofit agency Children and Families Come First was created for this role and is responsible for authorizing care and managing the process of caring by the system’s providers. The administrative structure of such a care management entity includes the capacity to both effectively manage resources and provide clinical supervision, to balance clinical and financial concerns in all decision making.

The principal staff group in the care management entity is the Care Coordination Unit, which consists of a group of care coordinators performing case management functions who are responsible for working directly with enrolled children and their families. (In Portland’s Partners Project such staff are called managed care coordinators; in San Francisco’s Family Mosaic Project—another MHSPY site—they are called family advocates.) Care coordinators convene and orchestrate care teams, which regularly develop and maintain individualized plans of care. (In Kentucky’s Bluegrass Impact program, child welfare workers chair the care teams, which consist of members who can commit resources from all of the other agencies involved.) The teams create a “common plan,” which is recognized by all of the agencies in the local interagency consortium. Under capitation arrangements, the plan of care serves as both the articulation of the clinical strategy and the means of financial control. Through the plan, services are authorized, and performance and outcomes are accounted for. The network of providers completes the delivery system, offering a full range of flexible services that can be tailored to the individual needs of each child as specified in his or her plan of care.

The special delivery system for child and family mental health care described here could serve as a specialty unit in the organized health care system of the future—as a secondary or tertiary care resource to primary care practice. New York State’s Section 1115 (Medicaid) waiver application makes provision for “Special Needs Plans,” which would serve children with serious emotional disturbances, as well as other populations with special needs. Or the system could serve as the organizational entity through which intensive care services could be delivered under a mental...
health “carve-out” arrangement, in which mental health services are insured separately from primary health care services.

**Financing.** The structures of interagency collaboration and the reorganization of local delivery systems are driven by financing. The bureaucratic wag says, “Form follows financing;” the prevailing “nonsystem” is the result of such a fundamentally irrational financing policy. A rational financing policy would deliberately shape the integration of effort that is necessary for children with severe emotional disturbances and their families. It would remove the artificial benefit limits for mental health care in traditional health benefit plans, both private and public. It would consolidate the resources of the six types of categorical agencies—child welfare, public health, mental health, education, juvenile justice, and substance abuse—into an integrated fund through which federal revenues could be maximized and by which seamless, integrated intensive care could be supported. It would administer the purchase of child mental health services in such a way as to use economic incentives to encourage individualized child-centered, family-focused care through risk-bearing prepaid contracts based on accountability for outcomes and consumer satisfaction. Finally, a rational financing policy would counter the tendency to select (“cherry pick”) less-disturbed patients, by introducing effective risk adjustment techniques that provide incentives for special child and family mental health systems to serve those with the most severe disturbances.

**Strategic Priorities**

Throughout the country, health care purchasers—especially employers—are reshaping the delivery of health care by demanding new, more effective organized systems of care. Public health agencies are rapidly joining this market-oriented health care reform effort by adopting a variety of techniques that are associated with managed care. This is an exciting time of both opportunity and risk for child and family mental health. Setting strategic priorities now will ensure that the health care system of the future is prepared to meet the needs of this vulnerable population. Progress will be real and lasting if we focus on the integration of child and family mental health care into the mainstream of U.S. health care, shift the role of responsible public agencies into that of aggressive purchasers of value for public dollars, and eventually integrate child and family mental health care into the primary health care system.

**Public and private integration.** The same quality of health care should be available to rich and poor alike. It is possible that the shift to market-oriented health care delivery and the eventual promise of universal health care will eliminate the quality gap that now exists between public- and
private-sector health care. This is happening as Medicaid-eligible clients enroll in private-sector health plans. The danger is that such plans will shift costs to private payers. In response, new public/private barriers will be devised by reliance on experience rating (setting prices based on the health care needs of a small, clearly defined segment of the population). But experience rating can be reconciled with community rating (setting prices based on the needs of the total population) by means of risk adjustment techniques. By introducing a manageable application of risk adjustment for high-cost patients with severe and persistent health care needs (who are normally the responsibility of public agencies), the conflict between experience rating and community rating can be resolved as health plans work for both private and public payers. Furthermore, by making risk adjustments for populations with special health care needs who then come into the risk pool with the Medicaid-eligible population, the need to integrate supportive social services as a part of medically necessary and appropriate care for populations with special health care needs will become clear.

Public agencies as aggressive purchasers of care. Probably the most demanding change in perspective called for by the movement toward market-oriented health care is that facing the officials who have run the public health programs. Medicaid, Medicare, and the categorical agencies have administered their health care services under some form of public entitlement law, largely based on the model of an indemnity insurance contract. Control of resources and quality of care under this approach is based on the prescriptions of law and regulation as well as on various kinds of licensing techniques. It is a different enterprise to purchase health care in a market-oriented delivery system in which consumers/members seek value (effective outcomes at a reasonable cost) for their health care dollars. Their satisfaction determines a plan’s competitive position in relation to other health care delivery systems. Public purchasers who cannot fully shift to being active purchasers could attempt to “reregulate” their programs under the format of excessive proscriptive detail in managed care contracts. If they do, they will simply destroy the advantages they might enjoy in obtaining high-quality health care in a competitive market. Employer purchasers have had a remarkable effect upon health care delivery by creating an atmosphere in which plans must adopt continuous quality improvement techniques and measurement of quality outcomes to survive commercially.

The Challenge For The Future

We have proposed a tightly integrated organization of the health care delivery system, based on the experience of a variety of reform efforts, to
assure child-centered, family-focused care with immediate access to a full array of flexible services and to serve as a template for a rational policy for child and family mental health care. It appears that the implementation of these special systems of care will accompany the widespread introduction by the states of managed care techniques through mental health carve-out arrangements: contracting through prepaid capitation for mental health services separate from the rest of health care. This has the advantage of concentrating on the development of child mental health care delivery systems, but it would be a mistake to allow this parallelism to stand. The health care needs of children are different from those of adults. In the case of severe mental, emotional, and behavioral disturbances, early intervention allows the full exploitation of the promise of growth and is the key to effective treatment. The special-purpose systems of care that we have described here must eventually be tightly linked with primary care and integrated into the emerging organized systems of health care delivery as secondary or tertiary care resources similar to other specialty resources or centers of excellence.

The authors acknowledge the efforts of families and professionals at the Mental Health Services Program for Youth sites who have effectively modeled integrated services delivery so that child and family mental health care can be brought into the mainstream of American health care.

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