Problem: Our Juvenile Justice System Frequently Does Not Respond in Developmentally Appropriate Ways to Children

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The juvenile court was born 125 years ago out of the critical observation that transgressions of the young should be seen in developmental context. This meant that the adult justice model: a system designed to both punish and deter, did not translate well to either fair punishment or effective public protection when applied to youth. Adolescents' unformed personalities, impulsivity, reactivity, and susceptibility to external influence meant they were both less culpable and more readily rehabilitated. The new model aimed to improve many practices, most significantly the underlying mission (to meet the transgressor's needs in order to correct a condition), and the expression of the court's authority (responding with supportive rather than punitive consequences). However, a fundamental flaw was that the system was at its heart designed in the manner of the adult system: an adversarial, sanction-based approach to punishing and deterring crime.

The adversarial model is quintessentially American: supporting individual freedoms and protecting against government overreach, and it can certainly be an effective way to get to the truth, but it necessarily leads to responses that are contrary to what we know works with youth. We know well that youth respond best to interventions that are collaborative; however, in an adversarial system, authority (adults, the justice system, even the state itself) is in direct opposition to the youth and potentially the youth's best interests. We know that to be most effective, responses to youth misbehavior should be rapid, positively oriented, developmentally appropriate, and implemented in close temporal proximity to the behavior of concern. Further, they should address and remediate underlying causes of behavior rather than simply provide an aversive consequence. However, resolutions in the justice system may take months, delaying interventions, and the focus on behavior often ignores critical context, like the role of trauma or proximal adult behavior. Whether an appropriate consequence or implementation of a needed support is delayed while the court process moves to its conclusion, opportunities for intervention are lost.

The reasonable doubt standard would be an unreasonable one for parenting interventions, where interventions are designed to support healthy development. In the court system, such a standard often means that many transgressions go unacknowledged, since we prefer false negatives to false positives (i.e., "not guilty" does not mean "innocent"). In most contexts, we would cringe at the notion of telling young people that they may reasonably try to get away with misbehavior if they think they can successfully pull it off, and that perhaps doing so may be the wisest course. In fact, for many parents, a child's failure to take responsibility for a misdeed would be worse than the initial transgression. Yet such efforts to avoid responsibility may make sense for an adolescent defendant in court, and an understanding of that right is a component of competence to proceed. The standard also means that the court may not impose any disposition for many youth who are factually guilty and for whom intervention could help them and protect against future transgressions.

Further, the approach inevitably is a muddied one, since some youth do pose immediate and serious threats to public safety, and few people would suggest that such risk of harm simply must be borne because young people may not fully appreciate the meaning of their behaviors, may lack the same capacity for self-control, and are ultimately likely to stop offending in adulthood. Thus, some youth are treated more like adults in the juvenile system, with responses from the courts that may well cause them harm, while other youth may be seen as children who need support and resources. Yet the latter group will carry forward a record of court involvement that may lead to lost opportunities and harsher treatment down the road. Experiences such as being placed in a detention center or being shackled can have lasting psychological effects; prior charges may impact treatment at school or in subsequent interactions with police; and involvement with the justice system may create restrictions or other consequences that impact later opportunities. Additionally, the very interventions designed to help may themselves cause harm.

In practice, the administration of juvenile justice has varied across time, location, and person. Like parents, different judges had conflicting ideas of what constituted best interest. However, unlike parents, they had the state's authority to incarcerate, and in a system in which defendant's rights are sacrosanct, it was inevitable that some advocates would argue that youth were no less entitled to these rights than adults. In the landmark case *In re Gault* (387 US 1 [1967]), in which 15-year old Gerry Gault was given a sentence that could have meant six years of incarceration for a crank phone call, the U.S. Supreme Court ruled that juvenile defendants were entitled to most of the constitutionally guaranteed rights granted to adults. The decision may have been the correct one given the harm the system was, at least in some cases, doing; however the sole dissenting justice's prediction – that as a result juvenile proceedings would increasing resembled those of adults – has been borne out.

None of the above is to say that the juvenile court system has not been a major step forward, but just that there will inevitably be problems, and those problems may be intractable. In fact, despite what are undeniably major benefits as compared with the prior approach, our juvenile justice is often ineffective at producing meaningful or lasting change. In fact, justice system processing is empirically an ineffective intervention: processed youth, on balance, do worse (i.e., recidivate more) than comparable non-processed youth. This is clearly a problematic state of affairs, made even more so by the criminalization of many typical adolescent behaviors and the clear findings that even youth with significant delinquency generally desist from serious offending as they move into adulthood.

Incremental progress may occur, but resolutions from within the current structure of the system are difficult to envision. Large-scale system changes that might be considered include creating a two-tiered juvenile court, with a level for low-risk youth in which the youth's best interests are the sole focus and the need for protections thus minimal, and one for higher-risk youth that would balance their needs with the public safety for cases and consequently look more like typical current juvenile court proceedings. Going farther, one might imagine a broader reconceptualization of the basic model in which the adversarial system is, at least initially, replaced by an inquisitorial one with a restorative justice approach. Such a model would fit with what we know more effectively changes behavior and could still serve as a gatekeeper to an

adversarial system. Our understanding of adolescent development and juvenile justice outcome research suggest that it would more effectively meet the goals of a justice system for youth: accountability, personal growth, the support of healthy development, guidance toward prosocial behavior, *and* improved public safety.

However, the creation of a two-tiered model or the replacement of an adversarial, sanction-based model of youth justice with an inquisitorial one would require fundamental changes in philosophy and practice. In the meantime, since processing with the justice system is an ineffective practice, and often a counter-productive one, the most effective way to improve the overall impact of the juvenile justice system on youth would be to keep more youth from coming before it.

To that end, a more manageable problem and more realistic proposed solution: Many adolescents come into contact with the justice system because of fairly typical adolescent behavior. They commit status offenses, repeatedly violate minor rules causing little harm, or their behavior escalates and becomes more genuinely problematic when in confrontation with authority. In such cases, they are thrust into a system that may cause them harm. In some cases, system involvement is unavoidable and appropriate, given that protection of the public is a necessary and important goal. But to the extent that justice system contact can be minimized (i.e., diversion when appropriate at the earliest point or prevention of necessary involvement from escalating further), it should be, and efforts toward that goal have the potential to help young people, improve the public safety, and save resources.

Much of the focus on reducing youth justice system involvement has been on providing appropriate interventions to youth who have already entered the system. Such approaches apply concepts from outcome research that focus on recidivism reduction and identification of unmet underlying needs (prominently including mental health and substance use treatment, skill development, and healthy adult support). Some efforts focus earlier in the process, including emphasizing the value of diversion after arrest at intake, before the processing of charges. Others aim even earlier, focusing less on interventions within the justice system itself but rather on early identification and remediation of the prevention of the problems that lead to justice system involvement. Each of these represents necessary and important work. However, another point of potential intervention is typically overlooked.

Police-youth contact may occur as part of routine police activity (when no wrong-doing is suspected and no intervention is needed), when police respond to or observe some activity that may be problematic or suspicious but is not itself illegal or an activity that may be illegal but for which arrest is discretionary, or when police respond to a crime and must take a youth into custody. In each of these situations, police responses may create, exacerbate, or fail to mitigate harm to the youth. Alternatively, police responses can also be supportive and helpful. The impact of such interactions can be immense in both the short- and long-term, and yet police officers in the U.S. typically receive minimal training to understand adolescents (about 1% of academy instruction), and consequently have limited skills to enable them to understand adolescents, prevent escalation, and de-escalate youth with whom they interact. Officers who understand adolescent development, the impact of trauma, and adolescent mental health are better equipped

to avoid unnecessary arrests and prevent the escalation of contacts to violence or force. Even when arrest may be necessary, they are equipped to respond in ways that will be more supportive of positive outcomes.

Officers tend to recognize their own limited knowledge and skills in this area and to want more training. Those who have received such training tend to report finding it useful. Nonetheless, it frequently does not occur, or is so limited that it does not offer meaningful skills. The absence of adequate training in the area reflects a number of factors, some of which are practical (police departments that do not have adequate staff or training resources) and some of which are ideological (opposition from those of one ideological perspective who want to defund the police or focus all equity efforts elsewhere, and from those from an opposing perspective who would argue that youth should not be treated differently and such training is thus not needed). However, the largest barrier may be the lack of attention to the importance of diversion at this point of initial contact, the value of such training, and its potential to both reduce youth involvement in the justice system broadly and to reduce disproportionate impact on minoritized and vulnerable groups.

The Box Problem vs. The Community Solution

Johanna Bergan

Children, youth, and families live within many systems each day. Some of these systems are organic in nature, built over time to help individuals survive and thrive by belonging to community. The African proverb, "it takes a village to raise a child," summarizes these systems well. Other systems are formal in nature, created and upheld by government and institutions. It is often the interplay, or the lack there of, that creates challenges in fully supporting children and youth in their mental health journeys. Over many decades the formal "children's mental health system" in its complex federal/state funded environment, eligibility requirements, and administrative oversight, has become too rigid and narrow in scope to meet the increasing demand for mental health supports of children, youth, and their families.

This critique does not universally dismiss the positive supports being offered today, and in fact relies on core tenants that have grown out of transformation of the mental health system over the last 30 years. These core tenants should continue to underpin the mental health solutions of the future and include the understanding that proximity to the problem increases the proximity to the solution. Centering patient voice and lived expertise in the mental health system is beyond essential. Authentic engagement and power sharing with youth and family in design, decision making, and delivery is best practice. The second core tenant is the understanding that the System of Care (SOC) framework has been adopted in mental health system design and delivery to a great enough extent that it can and should be viewed as the foundation to continue to build upon. The framework of a comprehensive array of community-based services and supports grounded in the core values of family- and youth-driven, community-based, and culturally competent care are solid and underpin the ideas presented here. Crucially, the SOC framework requires a commitment to continual renewal and transformation, without which the foundation would be much less desirable to use[1]. As change ripples through the system, the SOC framework can continue to evolve.

This tightening, boxed, understanding of the children's mental health system creates multiple problems. One of which is the creation of strong walls with limited doors that allow individuals into the system of support and a dramatic cliff when exiting the support of children's systems with no guarantee to an onramp into care and support in adulthood. Within the children's system there is a need to increase diversity in developmentally appropriate services and supports offered, and especially to develop interconnected, inter-funded engagement with adult services. The difficultly is illustrated in the shifting eligibility requirements to receive services as an adolescent than as a young adult, often stranding young people who received adequate children's mental health supports who are left with no form of support after aging out of that care[2]. The vast difference in approach to family engagement from child to adult systems also limits the successful resilience journey of young adults, moving from full engagement to almost a

[1] Stroul, B.A., Blau, G.M., & Larsen, J. (2021). The Evolution of the System of Care Approach. Baltimore: The Institute for Innovation and Implementation, School of Social Work, University of Maryland.
[2] Davis M. (2003). Addressing the needs of youth in transition to adulthood. *Administration and policy in mental health*, *30*(6), 495–509. https://doi.org/10.1023/a:1025027117827

repulsion to view family members as potential assets[3]. The fact that funding for children's and adult services stem from different budgets, often managed by different people, creates an environment of competition for funds rather than incentivizing financing childhood services (which should be noted serve as prevention dollars to the adult system). Where partnership and collaboration could exist at the intersection of these systems, disconnection and competition reign.

The firm distinction between those who meet eligibility criteria for severe mental health disorders and those struggling with poor mental hygiene and early emergence of mental health challenges creates sections of the population who are "in the system" and those who are not. This greatly hinders the transfer of knowledge and the shared responsibility for responding to mental health across the entire healthcare spectrum. Prevention efforts can be minimized rather can connected firmly to their role in reducing all levels of intensity of mental health challenges. The seeming separation of level of intensity and where services are received increases the stigma and discrimination experienced by those living with mental health challenges. The emphasis can be seen to focus on the mental illness of some rather than mental wellness of all. The disparities in accessing care (and how that care looks when received) are stark and show a lack of awareness of what equity should look like in mental health. Reigniting the call for mental health in public health feels critical.

While public awareness is growing around the alarming increase in mental health care needs of young people, evidenced by the regular media coverage and the issuance of a public health crisis by the US Surgeon General[4], there continues a disconnect between sounding the alarm and providing adequate services. The launch of the crisis suicide line 988 has been long needed but has been implemented with rapid pace and limited financial sustainability infrastructure. This launch amplified calls for help without full investment needed by the mental health system to respond. The long term and fully effective crisis response system will need to rely on the traditional mental health service providers (who will continue to need additional funding) and to engage new community partners and responders outside of the formal mental health box. A low barrier option to reach out for help is vital and 988 implementation should continue, however the work to fill in the current crisis response gaps in communities will take years to fill.

There is a way to approach these real world challenges and to walk towards a fully integrated health model, and to start the walls of the children's mental health system box need to become semi-permeable. Care for children, youth, and their families as they navigate mental health needs could become the work of everyone – across formal institutional systems and organic community systems. In this new approach several investments and leadership actions are called for, this include:

- Financing models where dollars follow the child/family across all systems and/or are blended to provide more options for service selection and diversity of intensity of service

[3] Walker, J., & Pearson, M. (2018). A Screeching Halt: Family Involvement When a Youth with Mental Health Needs Turns 18: Commentary on State of the Science from a Family Perspective. Portland, OR: Research and Training Center for Pathways to Positive Futures, Portland State University.
[4] Office of the Surgeon General. (2021). Protecting Youth Mental Health. Washington DC. US Department of Health and Human Services.

accessed (for example flexible funding found in Certified Community Behavioral Health Clinics[5] or money following the youth in transition services in Massachusetts[6])
- Continued research on which supports and interventions create outcomes desired by youth and families (rather than system leaders prioritizing outcomes achieved)
- Continued research on the outcomes of blended (or other innovative) funding streams particularly looking at return on investment of peer based services
- Open more doors to entry into mental health supports where any level of mental health need is addressed regardless of source point, from primary care to all youth serving systems including comprehensive school based mental health supports[7]
- Fund community-based advocacy and support partners especially including youth-run and family-run organizations[8] to increase capacity to engage in provision of support, leadership in change, and advocacy and agitation
- Center lived expertise in decision making within healthcare, peer service delivery, and system leadership
- Implement a developmentally appropriate crisis response system for children, youth, and families framed by national guidelines[9]

With innovative strategies and a willingness to learn from the past, there is a way forward to a coordinated and effective mental health support response. Striving for a continuous quality improvement way of being can support keeping the foundational components that work, reject that which is not, and allow for continual disruption and transformation to occur. Mental health care and support for children, youth, and families can and should be offered across our care continuum and not just a box one visits in some of the hardest moments of life.

[5] Substance Abuse and Mental Health Services Administration. (2023). Certified Community Behavioral Health Clinics. Rockville, MD. Substance Abuse Mental Health Services Administration.
[6] The Department of Mental Health Mass. (2018). Reframe the Age: Enhancing Practice to Support the Success of Young Adults. Commonwealth of Massachusetts.
[7] Hoover, S., Lever, N., Sachdev, N., Bravo, N., Schlitt, J., Acosta Price, O., Sheriff, L. & Cashman, J. (2019). Advancing Comprehensive School Mental Health: Guidance from the Field. Baltimore, MD: National Center for School Mental Health. University of Maryland School of Medicine.
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[9] Substance Abuse and Mental Health Services Administration. (2022). National Guidelines for Child and Youth Behavioral Health Crisis Care. Publication No. PEP22-01-02-001 Rockville, MD: Substance Abuse and Mental Health Services Administration.

Leonard Bickman

Bickman's Dictums[10]

Current mental health services are not sufficiently effective. Improving effectiveness should be our highest priority.

An umbrella meta-analysis on the intervention effects from 102 meta-analyses on 3,782 Randomized Clinical Trials (RCTs) for 650,514 adults concluded "After more than half a century of research, thousands of RCTs and millions of invested funds, the effect sizes of psychotherapies and pharmacotherapies for mental disorders are limited, suggesting a ceiling effect for treatment research as presently conducted. A paradigm shift in research seems to be required to achieve further progress (Leichsenring, et al., 2022)[11].

Weisz et al. (2019) on the basis of a review of 453 RCTs of children and youth over a 50-year period found that the mean effect size for treatment did not improve significantly for anxiety and ADHD and decreased significantly for depression and conduct problems.

Lack of attention to measuring outcomes contributes to insufficient effectiveness.
Without measurements there is no way to evaluate change or learn how to improve services (Samartzis & Talias, 2019).

Measurement based care (MBC) used to monitor clinical progress, evaluate treatment effectiveness, and support clinical decisions must be part of a usual standard of care but it is rarely used in practice. We are not learning from the billions spent on services (DeSimone & Hanson, 2023; Gelkopf, et al, 2022; Lewis, et al, 2019; Boswell, et al., 2022).

There is insufficient guidance on how to best implement PROMS - patient reported outcomes or ROMs – routine outcome measurement (Roe et al., 2022; Baandrup, et al. 2022).

Precision or personalized mental health care, the next big advancement in services is not possible without systematic outcome measurement (Bickman et al., 2016; Ranallo & Tennenbaum, 2021)

There are new attempts at consensus on measurement and investment in measurement development (Roe, et al., 2022; McKenzie, et al., 2022; Agarwai, et al., 2022; Cohen Veteran Network, 2023)

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[10] Dictum (definition from Merriam Webster) a formal pronouncement of a principle, proposition, or opinion/ an observation intended or regarded as authoritative.

[11] Citations are not based on an unbiased and exhaustive review of the research literature but are presented for illustrative purposes. The absence of a citation could represent what author believes is a "fact" that does not need empirical research for support or the inability of the author to find supporting research.

Quality assurance efforts are not a substitute for measuring outcomes since they have not been established to be related to outcomes.

Accreditation, certification, licensing are barriers to change and may at best only prevent the worst outcomes (Bickman, 1999; 2000; Zima, et al., 2019).

Clinician experience, training and certification may have a modest relationship to outcomes, but findings are mixed (Bickman, 1999; Frank, et al., 2019; King & Bickman, 2017; Ryan, et al., 2023)

The National Committee for Quality Assurance (NCQA) has moved too slowly with its low-cost, low effort HEDIS measurement system primarily based on electronic health records. For youth there are only 3 quality measures that simply address follow-up care, which may not be related to improvement. (Zima, 2020; Earla, et al., 2022). For Adults there are follow-up visits and recently added is achieving remission on a PROM (PHQ-9). However, research has found great difficulty in collecting this information in clinical settings (Morden, et al., 2022).

We must provide financial incentives to improve outcomes.

Mental health services are a commodity in our current system– one unit of service is equivalent to another because they are paid on a unit basis of hours or days instead of outcomes thus quality and effectiveness are moot.

Efficiency is more important than effectiveness under the current payment system.

Developing more effective services is not feasible unless effectiveness is incentivized. The Value Based Care Movement designed to value clinical outcomes is moving at glacial speed partially because of measurement issues (Pincus & Fleet, 2022: Bhalla, et al., 2022)

Improving access to services of unknown effectiveness is a distraction and is relatively easy but it may bring only delusional relief and make services worse by overloading them and wasting resources.

Lack of knowledge is not the major barrier to improvement but proper implementation what we know now would make services be more efficient and effective.

Changing the payer alone is a flawed solution–an illustrative example is the British National Health Services is a single payor and free service but once idolized now its worst-ever crisis is fueling a boom in private health care.

Acting for payers, insurance companies have major control over what services are provided but they will do what payers want as long as it is profitable for them.

Research based institutions are not sufficiently addressing practical problems of measurement.

Academics don't live in the real world governed by these dictums and shouldn't, but this is a major limitation to their contribution to improving outcomes.

Research funders like NIMH have provided little in the way of funding of measurement research. The National Center for Advancing Translation Research (NCATS), which has its mission to directly affect health services has funded little in the mental health area. The agency that focuses on patient outcomes, The Patient-Centered Outcomes Research Institute has not had a major role in mental health measurement. The Center for Mental Health Services does not fund research and has not provided much leadership in providing technical assistance in the area of measurement.

It is critical to causally connect services to outcomes.

Outcomes can be systematically improved only through intervention on their causes, and in no other way. Therefore, failure to distinguish causes from non-causal correlates – and without a diagnostic nosology to encode this distinction – cannot improve outcomes (Saxe et al., 2022).

Measurement of fidelity of implementation is critical to understanding the connection between treatment and outcomes (McLeod, et al., 2023)

A measurement feedback system is necessary to improve mental health outcomes (Bickman, 2008; Barkham, et al., 2023; Rognstad et al., 2022)

New Technology makes outcome measurement feasible and more useful.

New Technology is critical in improving the effectiveness and efficiency of services (Bickman, 2020)

Recent advances in causal data sciences (e.g., A.I.) makes the identification of the causes of mental disorders more feasible and the planning of RCTs more precise (Saxe, et al., 2022)

Advocacy is critical to actions needed to improve outcomes.

Caring and committed advocates can cause major changes but the solutions need to be carefully considered since they may have unintended consequences for example de-institutionalization (Roth et al., 2021; Koyanagi, C., 2007) and systems of care (Bickman, 1996).

Summary

Current mental health services are not sufficiently effective.

A lack of attention to measuring outcomes is a major contributor to insufficient effectiveness.

Quality assurance efforts are not a substitute for measuring outcomes since they have not been established to be related to outcomes.

We must provide financial incentives to improve outcomes.

Research based institutions are not addressing practical problems of measurement.

It is critical to causally connect services to outcomes.

New Technology makes outcome measurement feasible more useful.

Advocacy is critical to actions needed to improve outcomes.

A Solution

Improvement in measurement is required for any approach to improving the effectiveness of services.

We also need to recognize that the widespread use of routine outcome measurement (ROMs) is a complex undertaking that has significant barriers as we have learned from the Australian experience and others (Oster, et al, 2023; Barkham, et al., 2023).

We need an approach designed to improve outcomes that appeals to diverse stakeholders and is relevant regardless of the characteristics of the consumer, provider, setting, or treatment.

Create a Federally supported center that would be responsible for the following:

Infrastructure development and implementation of measurement feedback systems to allow for low-cost measurement and feedback.

Technical assistance to any provider of mental health services in (1) measure development and refinement (2) advanced trial design using AI (3) statistical analysis using causal discovery non-experimental approaches (4) advanced data collection e.g., ecological momentary assessment (Murray et al., 2023), use of intelligent chatbots and smart phones

Measurement development and refinement in high priority areas such as measure equivalency studies, translations, and new measures

Grant mechanism for funding small pragmatic trials with provider organizations short term, quick turnaround

locate in CMHS because they have extensive experience in funding mental health providers and community organizations.

Suggested partners:
Consumer organizations – NAMI, National Council for Behavioral Health, National Federation of Families, Mental Health America
Trade associations of providers - National Council for Community Behavioral Healthcare; National Association for Psychiatric Health Systems
Professional and Science associations, American Psychological Association, American Psychiatric Association,

Not back to the future
We have tried similar federal involvement in mental health measurement and evaluation before. The Community Mental Health Centers (CMHC) Program initiated with federal funding in 1963. In 1975 the government required that Centers devote 2% of their budget to evaluative efforts. It is generally accepted that this effort was not successful. We need to learn from these and similar efforts in moving forward (Aaronson & Wilner, 1983; Dowell & Ciarlo, 1983; Flaherty & Windle, 1981; Neigher, et al., 1983)

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Perhaps the most visible yet misunderstood and underexplored element of mental health is the dimensions of rage. On the one hand, deep rage is embedded in the core of most Black people and other racially subjugated groups. “Black rage” is rooted in the historical context of American slavery, segregation, and persistent racial discrimination, perpetuating systemic inequities and injustice within society. The accumulated trauma and daily experiences of racism contribute to intense anger, frustration, and a deep sense of injustice. The psychological effects of slavery, colonization, and racism in a white-dominated society (Fanon, 1986) are significant. One of the most significant manifestations of this rage is developing a sense of inferiority and self-hatred resulting from internalizing the negative stereotypes and prejudices perpetuated by white society (Jones, 2000; Fanon, 1986). Further, this rage manifests in additional ways, including aggression, depression, anxiety, chronic stress, and post-traumatic stress disorder (PTSD). While anger is a natural and healthy response to injustice, sustained exposure to racism can result in chronic rage that adversely affects mental health.

This chronic rage is also often a precursor to crime and violence. In isolation, rage can still lead to crime and violence; however, the combination of devaluation, disruption of Community, and dehumanization is usually present before the manifestation of rage (Hardy & Laszloffy, 2007).

The collective rage that most Black people and communities experience can be observed in their mistreatment in mental health systems, criminal legal systems, education systems, public health, health and healthcare systems, employment systems, and housing systems. The overwhelming and disturbing racial inequities within and across the intersection of these identified systems underscore some of the reasons for this rage. However, the reasons are much deeper than that, and, unfortunately, the mental health effects are not very well understood by the conventional mental health system. When contemporary remnants of antiquated anti-Black mental health system policies, practices, and procedures continue to produce widespread devastation and destruction to Black communities, there becomes an explicit and implicit understanding that Black mental, psychological, spiritual, and physical lives do not matter.

On the other hand, and more dangerous, is the collective white rage (Anderson, 2017) that manifests in response to Black calls for justice and equity. This rage, fueled by persistent anti-Black stereotypes, attitudes, and assumptions, has been used to control and disrupt Black communities through purported race-neutral and colorblind policies, practices, and decision-making at nearly every stage of a mental health workforce comprised of approximately 83% of white psychologist (U.S. Census Bureau, 2021). Contrary to popular belief, American mental health systems are deeply rooted in racism and racial bias. Thus, the neglect, under-exploration, and mainly absence of Black rage as a significant mental health issue is unsurprising in a mental health system dominated by white professionals. Therefore, black rage should be understood as a mental health issue deeply influenced by historical and ongoing systemic racism.

By implementing a comprehensive approach embedded in the Community Development Model (Robinson, 2005) that avoids the reductionism of cultural competence as the foundation of mental health services and focusing on education and policy change efforts that prioritize increasing the racial diversity of the mental health workforce, we can begin to address Black rage and work toward healing, justice, and improved mental well-being for Black individuals and communities.

Prameela Boorada

Let's talk about the youth mental health crisis. From the Office of the Surgeon General, to Behavioral Health Innovators, to Impact Investors, to Instagram Influencers — the youth mental health crisis is grabbing people's attention, resources, and investment. Yet, "crisis" seems too tame a word to encapsulate, what is quickly becoming, a dystopian reality. A world that's getting increasingly unrecognizable. Wounded systems that have long oozed out the seams of their band aid solutions. Individuals boot-strapping random wellbeing knick-knacks to survive until the next day. Apocalypse seems like a more befitting term for a problem of this magnitude, complexity, and possible irreversibility. While we aren't at the point of no return yet, it's certainly terrifying to stand so close that it's in view.

The fact is that youth nowadays are stuck in an insidious reality that feeds into itself - and influences detrimental short-term and long-term outcomes. On a macro-level, youth are navigating historically unprecedented social conditions. The social, educational, relationship, and professional landscapes have increasingly migrated into a digital world. While the shift to digital-socialization has already been in the works, the pandemic forced an accelerated timeline that called for near-immediate adoption of these changes. In addition, youth are dealing with an astronomical increase in existential threats. On a global level, climate change has steadily worsened over the years and led to detrimental natural disasters in recent times. On an international level, there are several long-running and recent socio-political conflicts that have severely impacted the lives of those in the affected areas — and created an environment of unease and unrest across the world. On a national scale, there has been a surge in domestic terrorism — manifesting as mass shootings, police brutality, and hate crimes. While most people do not expect to interact or be impacted by these macro-events – their proximity and frequency has been increasing. Worse yet, the devices in our hands keep young people stuck in endless scrolling of doom, crisis, and helplessness.

Yet that's not the end of the nightmare. While the problems are quite bad — the solutions somehow seem worse. When seeking services to deal with an increasingly dysfunctional world — young people are encountering inadequate, inaccessible, and inequitable mental health services on an institutional and systemic level. Despite the best efforts to inculcate cultural humility and LGBTQ competence into practice — most clinical spaces remain largely unprepared to work with people of minoritized, and often marginalized, identities. This happens, in small part, due to a lack of BIPOC and/or LGBTQ+ mental health service providers — and, in large part, because of active erasure of BIPOC and/or LGBTQ+ contributions to the theories, frameworks, solutions, and services in the mental health space. While the inequity in the state of services is quite concerning - it doesn't even begin to touch on the fact that there is also a lack of awareness, availability, accessibility, and affordability in services. For instance, non-emergency services are few and far between. Peer-support services are largely unheard of outside of substance use support. Despite a myriad of digital therapeutics on the market, the shortage of mental health professionals still persists.

Unsurprisingly, the aforementioned conditions have compelled young people to look out for alternative solutions. Thanks to social media being the primary point of connection during the pandemic — there has been a surge in mental-health storytelling where people are openly sharing their life experiences across the world. Similarly, several therapists have taken to educating masses through these platforms. There's a greater number of digital services now available. In fact, several interventions even exist outside of the healthcare system — making

them more approachable and accessible. In instances where an effective solution doesn't exist — different communities have put in the direct effort to build personalized solutions. On one hand, the resourcefulness to seek out/ build solutions is praiseworthy. On the other hand, what's alarming is that a majority of these alternatives are largely unregulated, misinformed, inconsistent, and rapidly changing.

So, yes, we are collectively walking towards the precipice of a youth mental health apocalypse. And young people just woke up to find themselves at the frontlines.

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Counter-intuitive and dramatic as it may seem, the use of "Apocalypse" as a descriptor wasn't intended to submerge us in doom. Instead, it was meant to evoke hope. The deteriorating condition of this world is becoming less of an eventuality and more of a reality. In order to build solutions for young people, we need to accept their reality as our problem-space – with all of its constraints and brokenness. Youth leaders are already designing ways to heal amidst this mess – what we need to do is to co-create solutions with them and build structures in a way that will empower their agency, innovation, and disruption.

To do so, we need to start at square one. Informing and equipping young people with resources and resilience creates an environment for them to explore, experiment, fail, and flourish on their own terms. More importantly, the right education — at the right time — empowers the courage and audacity to innovate. Innovations, with the right support, have the power to ignite a collective movement. The beautiful thing about movements is that they have the ability to birth new ecosystems. As idealistic as it seems, youth leaders have shown, time and again, how to operationalize these efforts.

To kick things off, it's important to design an iterative mental health educational model (similar to an evolving model of learning for physical health and education) that can be implemented in K-12 schools. Here are some important considerations for this curriculum:

1. Being grounded in positive psychology could move us – away from a pathological lens and – towards frameworks, models, and scaffolding to learn, explore, and internalize skills like creativity, leadership, resilience, etc.
2. The pandemic, unfortunately, deepened feelings of loneliness, stunted emotional development, and complicated our understanding of connection. This curriculum should serve to evolve one's understanding of emotions i.e. teach how to navigate the process of naming, recognizing, holding, processing, feeling, and resolving different emotions.
3. Young people are each other's first support when navigating mental health crises. Teach kids peer-support skills in an age-appropriate manner and advance those skills each year by including actionable ways to address mental health episodes, mental health crises/ emergencies, suicide prevention, trauma (ex. School shootings), etc.
4. Given the heterogeneity innate in American society, it's important to position identity, intersectionality, lived experiences, and societal systems through the lens of their bidirectional influence on mental health. This curriculum could explore mental health from the lens of race, gender, sexual orientation, family, politics, patriarchy, faith, etc.

One important aspect to consider is that this education needs to continue beyond the school's boundaries. A part of destigmatizing and normalizing mental health conversations for young people is to make this content readily available online. That being said, it's important to develop standards and constraints for mental health content in digital spaces. For example – define clear standards for a verified clinician's account in digital spaces (esp. social media),

determine the constraints for what can/ cannot be discussed online on a public account, etc. Establishing these standards is crucial to avoid blurring lines between mental health storytelling, self/ peer-diagnosing, and sharing clinical advice in digital spaces.

As mentioned above, a significant (and hopeful) outcome for education is mental health innovation. It's important to diversify and expand the current definitions of behavioral health innovations to include community-based solutions, ancestral/ cultural practices for wellbeing, intergenerational approaches, etc. While advocating for these diverse solutions and elevating the voices of those with lived experiences with mental illness in these conversations is a significant first step — it's important to take it a step further and establish a National Council that can oversee and advise on adolescent behavioral health innovations. Currently, the mental health innovation ecosystem — whether that takes the form of products, programs, or public-private partnerships — consists of several national/ state/ local organizations and are largely silo-ed. Having a unified entity that could provide structure, resources, and guidance to grass-roots (but highly effective) community efforts would be highly effective — and elevate them to the same level as private efforts.

Ultimately, all of the aforementioned efforts would be rendered useless if we do not center youth leadership in the forefront of solution building. It is no longer enough to invite them to "the table", source their insights, and advise on their ideas. Despite a plethora of youth councils and advisory boards, there is a noted failure in catalyzing meaningful transformation because these disjointed efforts are unable to build long-term impact, collective power, or sustainable ecosystems. To dismantle systems that no longer work, we need to actively shift power to those building disruptive solutions.

In the light of collective discomfort and resistance over shifting power to young leaders– I want to illuminate the recent accomplishments of several youth leaders across the country. Over the last few years, youth leaders have:

1. Built mental health education and peer support programs across the country.
2. Created (and spoken at) conferences, discussion spaces, digital content, and podcasts on: AI x mental health, social media x mental health, community-based efforts, diverse and equitable practices, critical psychiatry, etc.
3. Launched products and programs that address the needs of marginalized communities
4. Developed national movements for several social justice issues that are ultimately rooted in mental health advocacy
5. Expanded leadership efforts beyond school/ collegiate/ youth-serving organizations to be an active voice in the boards/ councils for national and global organizations.

We can't expect young people to be our hope for a better future while withholding the wisdom, tools, and power to build that future.

Bruce Chorpita
This material comes from an edited version of the following peer-reviewed paper and thus should not be circulated beyond the group meeting in Omaha, NE in August 2023, organized by Bill Reay, without obtaining permission first:

Chorpita, B. F. (2019). Metaknowledge is power: Models to address unmet mental health needs. *Journal of Child Psychology and Psychiatry, 60,* 473-476.

The crisis in mental healthcare is longstanding, unambiguous, and uncontested, and we should be deeply concerned. Human suffering due to mental health concerns is extensive, and only a fraction of it is addressed, despite decades of public and private investments in solutions. On a global scale, most people with needs still get nothing at all, and the rest often get something that has little chance of helping. There are incentives for researchers and policy makers to come up with quick and simple answers to this complex problem ("everything should be free and open source," "simpler solutions will be scalable"), which are a distraction from the core strategy failure of how humans have organized themselves to take care of their mental health concerns.

In a position paper in 2019, Kazdin eloquently described multiple factors contributing to this failure, all of which are widely recognized, including cost, stigma, policy, service accessibility, and an insufficient workforce. In a critique of current psychotherapy delivery models, Kazdin also challenged three major cornerstones of traditional psychotherapy: how it is delivered, who can deliver it, and where it is delivered. I responded at the time saying that we need to take the challenge one step further (Chorpita, 2019), noting that these limitations of treatment delivery models are fundamentally linked to a deeper problem with the knowledge architecture in clinical science. Simply put, we package what we know from research in ways that serve the needs of researchers and publishers, but the stored knowledge is fragmented, difficult or impossible to retrieve, exceedingly complex to aggregate, and nearly impossible to use for those in the service world who are concerned with helping others—I am waiting for someone to disprove my claim that at least 99% of children's mental health service systems do not use at least 99% of the clinical trial literature in children's mental health.

The Problem
We have packaged what we learned about improving human functioning into discrete 'treatments,' reifying them into highly specified products or procedures. This model was created through decades of research, with an emphasis on randomized trials, manualized treatments, and replication with fidelity. Yes, it moved the field from a worrisome practice climate with few guideposts, but it is time to reconsider these models and their utility for maximizing health impact. Ironically, the tools and conventions that built our research evidence base may now limit the application of that very same evidence base. How is that possible? It is because conceptualizations of evidence-based treatment that have prevailed for roughly 30 years have focused practice and research policy far more on the products of research than on the emergent knowledge behind them, transforming an industry of knowledge discovery (e.g., academic research) into an industry of product development and validation. We are now limited by its implicit assumption that only the products are useful (e.g., specific manuals, as recognized on

registries) and not the generalized knowledge they represent (e.g., rewards can increase the probability of future behavior). The problem is compounded by academic incentive structures for innovation, which means that the field's most capable minds are encouraged not to collaborate or coordinate their discoveries, but instead to reinvent the wheel, with a different name or brand for treatments with almost entirely the same procedures (see Okamura et al, 2019). We now have 1,004 manualized evidence-based treatments for youth, which are primarily reassemblies of the same clinical procedures that have existed since the 1980s. Consequently, we have also wasted almost two decades investing in fidelity measurement and protocol hyper-specification, when evidence overwhelmingly suggests that there are many different effective ways to reduce anxiety through exposure, to reinforce positive behaviors, or to boost mood using pleasant activities. The current paradigm carries an insurmountable burden of testing, replication, and selection. Randomized trials for all interventions in new and diverse formats, in all contexts, with every workforce, with every culture, in every setting for every age group cannot be achieved, even if all research shifted from developing treatments to testing their contextual extensions. The problem is similar with respect to choosing among treatments already found to be effective. For example, picking only five evidence-based youth treatment programs to be available in a mental health system from an evidence base of 1,004 yields over 8.4 trillion possible treatment arrays. Human system designers cannot make these choices without consequential errors. The paradigm grows even more troubling where it intersects with implementation science, which would mean that nearly limitless validations are then multiplied by the burden of replicating specific implementation methods. We should therefore move away from thinking about highly specified 'treatments' and begin to think about therapeutic action in an entirely new way.

A Knowledge Management Perspective

Addressing unmet mental health needs thus requires moving the knowledge behind the ever-growing list of treatments into as many relevant decision-making contexts as possible. A concrete illustration of this difference is that maintaining a 'treatment' perspective might suggest that a version of parent management training should be offered through an online social media platform, where it will reach more people, more cheaply, with less stigma. However, a knowledge management perspective would propose that all actionable elements and principles of parent management training should be distributed beyond formal treatment contexts. For example, the utility of labeled praise to increase desired behavior should be shared through social media, promotoras, or mobile apps not only with parents in need, but also with school bus drivers, teachers, soccer coaches, store clerks, custodians, and librarians, because they all encounter the very same children those treatments are intended to support. If you can ask your phone where to get a cheeseburger, then you should be able to ask how to help your child fall asleep, how to approach making friends, or how to improve low mood. The internet is often used this way already, but because the underlying architecture is not there the quality of information is unknown and often risky (King et al., 2021). We should all be able to ask questions to the evidence base and get trusted, scientifically grounded answers.

A Caveat

Removing the specific requirements of thinking solely in terms of treatments risks painting a vague picture in which any approach to helping people is as good as any other—a chaotic lack of conventions and standards. To be clear, a vision of therapeutic activity that is not limited to or

bound by ‘treatments’ is certainly still limited to and bound by evidence. This is not a call for lack of order—quite to the contrary, it is a loud call for an ordered framework, a defined knowledge architecture, complete with semantic representations and formal knowledge provenance, for how to make best use of what we know, whether through defined treatments or otherwise. It is a call for metaknowledge. To that end, Eric Daleiden and I recently articulated principles of Coordinated Strategic Action (CSA; Chorpita & Daleiden, 2018), which involves the purposeful arrangement and management of resources (e.g., people, technology, knowledge or evidence) and activities (e.g., training, coaching, delivering therapy) in pursuit of established therapeutic goals.

This reorganization will not be simple, and it will not be free. But it could finally create an enduring infrastructure that is cumulative and actionable. Sophisticated practices for managing large evidence bases exist throughout industry (e.g., streaming movie recommenders, faceted searches for retail items), but they are largely absent in mental health (see our 2022 National Academies of Science report on the need for ontologies in behavioral science). We need to organize what we know around specific use cases in clinical service contexts and in all contexts in which youth mental health functioning is potentially modifiable. Robust models for this approach exist, and they have the potential to enable new workforces, new tools, as well as the many new delivery formats called for by Kazdin in 2019. We can achieve a vision of therapeutic intelligence, in which we have tools that make everyone work smarter, regardless of their credentials, and that can answer the basic questions from professionals, parents, teachers, and community members about what to do when for children in need.

Preventing Child Neglect and Unnecessary Out-of-home Placements in At-risk Families

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Problem: The problem addressed is preventing child neglect in at-risk families while at the same time minimizing unnecessary removals of children from their biological parents.

Child neglect accounts for 76% of all U.S. child protection cases and 78% of child maltreatment fatalities (https://www.acf.hhs.gov/cb/report/child-maltreatment-2021)/. Neglectful care has lifelong physical and mental health implications (Rozanski et al., 2021). One group of parents who are considered to be high risk for neglect are parents with cognitive disabilities (e.g., intellectual and developmental disabilities, borderline intellectual abilities, acquired brain injury, FASD, severe learning disabilities). As a group, children of parents with cognitive disabilities are at risk for perinatal, developmental, academic, and behavioral problems (Feldman et al., 2011; Feldman & Walton-Allen, 1997; Rubenstein et al., 2021). Note that often these child studies are conducted on families who may not be receiving appropriate supports, such as adequate prenatal care and parent education.

Children who have parents with cognitive disabilities are over-represented in child protection cases and are much more likely to be removed from their parents' care than children of parents without cognitive disabilities (Laliberte et al., 2017; McConnell et al., 2021). Many U.S. states list parental disability in general or intellectual disabilities, specifically, as grounds for child removal without requiring evidence of child maltreatment (Lightfoot et al., 2010). A recent U.S. study using national administrative data found that 56% of parents with intellectual disabilities were not living with their children (Stancliffe et al., 2021). This child removal prevalence is somewhat higher than the estimated average of 40% found in other countries (Llewellyn & Hindmarsh, 2015).

Child removal often is based on the ableist assumption that cognitive limitations preclude the parent from being able to provide (and learn to provide) adequate care and nurturance to the child and that it would be in the best interest of the child to place them in care (Feldman & Aunos, 2010). Indeed, most legal justifications for termination of parenting rights rest on evidence of low intelligence obtained through a parenting capacity assessment (Callow et al., 2017). However, concerns have been raised about basing custody decisions solely or primarily on intelligence testing as a proxy for direct assessment of parenting knowledge and skills (Feldman & Aunos, 2010). The assumption that child removal decisions should rest exclusively on the best interests of the child has been challenged (Ainsworth, 2021) especially given the potential long-term negative mental health outcomes of foster care (Font, 2020).

Solution: Feldman (2002) presented a contextual model as an alternative to the simplistic and inaccurate assumption that parenting inadequacies are a direct result of intellectual deficiencies. Extending the ecological models of parenting (Bronfenbrenner & Ceci, 1994; Belsky, 1994), Feldman (2002) identified numerous proximal and distal variables that interacted over time to impact parenting skills and child and family outcomes. Proximal variables include the parent's current physical and mental health status, social support, family situation, life crises, and child characteristics. Distal factors that could influence parenting include parent's history and social factors (e.g., stigmatization, discrimination, exploitation). Parents with cognitive limitations tend

to have multiple risk factors for child maltreatment such as experiencing trauma and oppression, poverty, poor health, and social isolation (McConnell et al., 2021). These contextual variables are stronger predictors of adverse outcomes than IQ scores and when these hardships are controlled for, differences in maternal health, child outcomes, and child protection decisions between families with parents with and without cognitive disabilities are significantly reduced or eliminated (Feldman & Aunos, 2020).

To prevent or remediate child neglect and reduce unnecessary child removal, a valid and comprehensive parenting capacity assessment (PCA) should be conducted that eschews a focus on the parent's intelligence and instead focuses on identifying the family's contextual variables that are sources of strength or present barriers to successful parenting (Feldman & Aunos, 2010). This contextual analysis should be coupled with a functional assessment of parenting knowledge and skills using objective measures such as observational checklists found in the Step-by-Step Parenting Program (Feldman, 2022). A thorough PCA should identify needed services and supports that could protect the child and keep the family together.

Often support needs revolve around providing an effective parent education program that teaches parenting skills that the parent is missing or not preforming adequately and thereby putting the child at risk for neglect. Over 30 years of research has identified components of effective parent training for parents with cognitive disabilities, that are captured in the Step-by-Step Parenting Program (Feldman, 2022). These components include building rapport and trust with the parent; collaborating with the parent and child protection services; teaching in the family home (i.e., weekly home visits); task analysis and ongoing observation of specific parenting skills; and enhanced behavioral skills training. Behavioral skills training within the Step-by-Step Parenting Program consists of simple instructions, prompting, modeling, visual teaching aids, frequent practice, immediate positive and corrective performance feedback, and generalization and maintenance strategies (Feldman & Tahir, 2016).

Research on the Step-by-Step Parenting Program demonstrated quick improvements in a wide-range of parenting skills (to levels seen in nondisabled parents), benefits to the children's health and development, and significant reductions in permanent child removal (Feldman et al., 1992, 1993). The provision of an evidence-based parent training program specifically designed for parents with cognitive disabilities is an integral part of preventing and remediating neglectful care and potentially allowing the child to stay or be returned to the home. However, often the family has additional needs that should be addressed. Families may benefit from building a strong natural social support network, mental health and/or substance use interventions, and poverty alleviation programs. To build system capacity, among other things, child welfare professionals need educational programs on working with parents who have cognitive disabilities and tackling personal and systemic discrimination towards parents with disabilities (Pacheco et al., 2022). More research is needed to determine if providing a comprehensive, contextual-based parenting assessment, evidence-based parent education, and other needed services and supports will result in long-term reductions in child neglect and out-of-home placements for families headed by parents with cognitive disabilities. In the meantime, given the potential of evidence-based parent education, the high rate of child removal, and the financial and personal cost of foster care, the approach described here deserves consideration to replace current practices based on misguided assumptions of parents with cognitive disabilities.

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How can we capitalize on current public attention to the mental health care crisis?

Ann Garland, PhD

Is there anything fundamentally new about the current mental health care crisis? Or is it an extension of crises many in this forum have highlighted for decades, namely, limited resources, access disparities, fragmented services, and lack of integration between science, practice, and policy? Perhaps what's new is the heightened public visibility of the crisis in the popular media. I look forward to discussing how we can capitalize on this heightened visibility to inspire policy, funding, and research advances. In this brief statement, I'll offer thoughts on (1) how a public health approach can help frame our understanding of mental health care problems and solutions, and (2) workforce development challenges and solutions.

Public Health Approach

Reinforcing the narrative of the mental health crisis as a **public health crisis** is useful because it is a familiar framework and public health approaches value inclusive community partnerships to bridge science, practice and policy. Using basic public health concepts such as primary, secondary and tertiary prevention to differentiate types of interventions is also essential for clarifying mental health problems and solutions. Current public perceptions of mental health care are too undifferentiated, lumping everything from generic wellness support (e.g., relaxation exercises) to intensive treatments together. Greater specificity can support strategic advocacy for evidence-based interventions at each necessary level, as noted:

Primary Prevention: We have learned a great deal about a wide array of risk factors for mental illness, including social determinants such as poverty, child maltreatment, discrimination, alienation, racial violence, gun violence, sexual violence, homelessness, etc. I'm encouraged to see growing public awareness about how adverse childhood events (ACES) are associated with poor health and mental health outcomes, but we need to keep reinforcing this linkage so it is as clear to the public as link between smoking and lung cancer, etc.

Likewise, we need to be more explicit about promoting mental health protective factors. Public discourse advocating for "mental health wellness" is ubiquitous but it is too vague. Existing science supports greater specificity. For example, social-emotional programs that boost children's emotional regulation skills can protect against a range of mental illnesses (Ialongo et al., 2019) and support for "Gay-Straight Alliances" in schools can reduce victimization and alienation (Marx & Kettrey, 2016). Greater specificity about the science on protective factors can strengthen advocacy for increased investment.

Secondary Prevention: We also have a strong scientific literature identifying individuals at elevated risk for mental health problems as well as validated tools to screen for risk. We need to deploy screening programs in schools and primary care more broadly to identify those at elevated risk for issues such as depression, suicide, anxiety, eating disorders, ASD, etc. and implement pathways to evidence-based interventions. While there will always be room for

improvement in measurement feasibility, validity, and ethical safety - not to mention available treatment once screened - current methods are effective and ready to scale up.

We also need to make stronger arguments for expanding treatment resources for specific groups known to be at greater risk for a variety of mental health challenges, including those in child welfare or juvenile justice systems, children of incarcerated parents, etc. We have so many demonstration projects documenting effectiveness for targeted interventions for these specific populations (e.g., parent-training programs for children in foster care which significantly reduce placement disruptions and improve children's stress resilience (Fisher et al., 2006). We need to invest in wider dissemination and implementation of such interventions.

Tertiary Prevention: Our scientific knowledge regarding effective psychosocial treatments has increased significantly, and we are now learning more about effective implementation strategies to disseminate and sustain effective treatments. We've also established the value of measurement-based care and have emerging technologies to support it. Yet, frustratingly, our public mental health outcomes don't reflect these treatment advances.

One of our current challenges is to disrupt traditional assumptions (among providers, policy makers, and clients) about what effective treatment may entail. Some of these "disruptions" are conceptual such as support for the effectiveness of trans-diagnostic treatments and modular approaches implementing carefully selected practice elements derived from different empirically supported treatments (which our team refers to as "common elements of evidence-based practice"). Other disruptions are more radical such as highlighting the potential impact of very brief (e.g., single session) interventions (Schleider et al., 2022) as well as a wide variety of web and app based interventions, many capitalizing on AI advances (Bickman, 2020) and the use of paraprofessionals in effective care (Barnett, et al., 2018).

Expanding notions of effective treatment to include a much wider array of options will help us to address the significant unmet need. We are learning that there are more cost-effective options than traditional multi-session individual or family psychotherapies led by licensed professionals. Now we need research to identify who may benefit from different types of interventions to inform triaging guidelines.

Workforce Development

We should capitalize on current public awareness of workforce demand with strong advocacy for funding and training advances. Without question, we need to increase the number of trainees pursuing mental health careers across disciplines. However, increasing the number of trainees without attending to the quality of training programs would be foolhardy. (And yes, we definitely need more research to define and identify components of quality training)

Workforce development challenges include objective and subjective barriers. Objective barriers include lack of diversity among trainees; expense of training; job salary weakness in some professions; lack of support for mentoring and supervision of early-career professionals; and discipline specific academic accreditation and licensure bodies that dictate program curriculum and sometimes build bureaucratic barriers in training advancements.

Potential solutions to these challenges include expansion of training grants (such as HRSA funded stipend programs) and loan repayment programs, as well as financial support for

community-based service providers to provide supervision and mentorship (see, for example, California's new program: https://www.workforce.buildingcalhhs.com/mentored-internship-program-mip). Also, we need to work more closely with accreditation and licensure bodies across disciplines to make sure requirements reflect the science on effective training (eg., training and ongoing supervision in evidence-based assessment and intervention, measurement-based care, use of observation data in clinical supervision, etc.).

Subjective challenges in workforce development include pervasive confusion and often misinformation about the similarities and differences across disciplines, degree programs, and career paths; trainees' limited knowledge of the wide array of career opportunities (e.g., beyond traditional private practice); and significant variability in the extent to which training programs embrace integration of science-supported practice.

A crucial question for us to address is, **how do we inspire more individuals to enter the field and make sure they are well prepared?** Anecdotal evidence suggests that most students who pursue a mental health practice career (particularly those applying to master's degree programs who represent the majority of the workforce) are motivated by compassion, social justice, and often their own (or family and friends') mental health care experience. These are worthy and powerful motivators, but it is a shame that aspiring professionals rarely cite scientific advances as career inspiration. How can we recruit those who may also be motivated by scientific innovations, technological, and data science advances? We need more strategic pipeline development in high schools, community colleges and universities to shift the narrative about mental health careers, highlighting the meaningful opportunities to compassionately advance social justice ideals using interventions supported by innovative science. I'm envisioning a campaign to inspire individuals to pursue this career for both humanistic and scientific interests. This could expand the potential pool or professionals and prime them for integrating science and the healing arts throughout their career.

What's my role and/or contribution to the system?

My roles - and hopefully contributions - to the mental health system have been in training practitioners and researchers, as well as leading applied research efforts.

Training: I am an unusual psychologist in that I have never worked in a psychology department, but rather in departments of psychiatry, counseling, and marital and family therapy. This gives me a somewhat unique perspective on similarities and differences across disciplines and degree paths (i.e., doctoral and masters), and how to find the best fit for prospective trainees' strengths. My recent book addresses these and other workforce training challenges and opportunities.

Research*:* Over 30 years, my research has addressed: (1) identifying the need for and use of mental health care among specific populations such as children in the foster care; (2) understanding the complexity of measuring outcomes of mental health care, particularly across different stakeholders' perspectives; (3) identifying racial and ethnic disparities in access to care; (4) identifying common elements of evidence-based treatments; (5) examining "usual" community based psychotherapy practice and the extent to which it aligns with common elements of evidence-based treatments. I'm particularly proud of our team's work advocating for

the pragmatic utility of identifying common elements of evidence-based treatments despite initial resistance to this approach and I'm encouraged by growing acceptance of it.

I'm also proud of the fact that virtually all my research has relied on partnership with community-based providers, and sometimes clients. After decades of work that broadly addresses bridging the gap between research and practice, I'm consistently reminded that relationship building is the key. I have witnessed successful bridging, where different constituents have built sustained trusting relationships with mutual benefits, but so far, I haven't identified any shortcuts; it takes lots of time and motivation but it is worth the effort.

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Lawrence (Larry) D. Gendler

There are a myriad of issues vulnerable children, and in many instances their parents, encounter when placed in the "system." We know from experience that change can be had, hope can be restored, and permanency can be achieved. But sometimes these positive outcomes are delayed, or worse, a pipe dream because of how these folks are treated by those assigned to help them. We must also be careful not to criminalize adolescent behavior and reserve court involvement for those that pose a danger to their community or their families.

The most important issue, for me as a judge, was to garner the trust of those who appeared before me and ensure that hope was not an abstract concept. Nobody walks into a courthouse expecting a good time unless it is for an uncontested adoption or guardianship. Almost all who walk into a courthouse fear what may happen and unsure about the proceedings particularly for those who are Black or Latino. Many have firsthand accounts of mistreatment by courts and those assigned to help.

During my tenure as a judge, I visited the penitentiary several times to visit with inmates who as children found themselves under the jurisdiction of a juvenile court judge. Most of those I visited started out in the system as abuse or neglect victims. They told me judges, lawyers, case workers, probation officers, and other professionals could not be trusted. They felt they could not speak for fear of punishment, or worse, indifference. As a result, they (and their parents) chose not to engage with assigned professionals.

I have over the years seen others, well intentioned, brag about their programs, their new evidence-based practices, their willingness to take on new challenges with all of it branded to look enormously successful only to waste valuable dollars and time with little to no discernable difference in outcomes. I have also seen some who provide services in offices with no matching chairs, tables more appropriate for a garage sale, and staff who have lived experiences (with the scars to prove it) who connect with their clients, listen to their clients, and achieve tremendous outcomes.

I had two friends, who have since passed, that provided addiction services and facilitated groups with better outcomes than anyone or any organization. They connected with folks and their clients trusted them. I witnessed firsthand in their groups the personal stories of how courts mistreated them, addiction services pigeonholed them, and hope was a fleeting dream. I learned from them appearances were worthless, that listening to personal histories mattered, and that most when given a voice will engage and grow.

I do not discount the need for important and effective evidence-based services. However, if the issues of trust and hope are never addressed none of it will matter. While academics have their research, providers have their programming, and professionals have their credentials, the child (and the parent) who craves normalcy and hope will know neither unless the system and those assigned to help can truly be trusted.

Thoughts about Child, Youth and Family Mental Health Services in the U.S.

Kimberly Hoagwood

May 30, 2023

"As long as we have altitude and ideas, we'll be okay."

Capt. Tammie Jo Shults, Pilot of SWA Flt 1380

The Biggest Problems

This country faces a fundamental problem in promoting healthy child development, which is, after all, the goal of services. This problem is essentially moral. As a country we lack a societal ethic that privileges children's healthy development. We lack a child-first ethic. As a result, services (when available) are only available to children and families after the fact—after problems have arisen. If instead there was an explicit societal mindset that children's healthy development was paramount, demanded immediate attention, and had to be prioritized, then communities and their leaders could craft policies with prior consideration of their impact on children's development. Much like the "health in all policies," we would routinely take into account the impact of policies (e.g., health, transportation, climate, housing etc.) on children, and act accordingly.

The second big problem is systemic: This country lacks a flexible, data driven, universally accessible, coordinated and accountable network of health services. Health insurance and regulatory systems are competitive and profit-driven, and they prioritize profit over health promotion. Insurance coverage, if available, is inadequate to cover basic preventive services. Services don't follow the child. They follow the money.

These societal and system problems have led to severe fragmentation, lack of accountability, inefficiencies, poor quality, and immoral racial, ethnic, gender and disability inequities, all of which lead to deleterious outcomes for children and families and largely explain the rise in mental health problems.

Some basic and embarrassing facts: According to a Commonwealth 2021 Report, the U.S. ranks last overall on health care outcomes in comparison to all other developed countries. On nine of 10 measures, U.S. performance is lowest among these countries. This includes having the highest infant mortality rate (5.7 deaths per 1,000 live births) and lowest life expectancy rate. The U.S. rate of preventable mortality (177 deaths per 100,000 population) is more than double the best-performing country, Switzerland (83 deaths per 100,000). The U.S. also has exceptionally poor performance on rates of maternal mortality.

In contrast, top-performing countries all share these common elements: (1) They provide universal health coverage and remove cost barriers so people get care when they need it. (2) They invest in primary care systems to ensure that high-value services are equitably available **locally** in

all communities, thus significantly reducing health disparities. (3) They consistently invest in social services to increase equitable access to nutrition, education, child care, community safety, housing, transportation, and worker benefits, so the population as a whole is healthier and makes fewer demands on health care.

If we are serious about reducing mental health problems among children , then we have to acknowledge the underlying reasons for it. The failure of our health system and the lack of a societal ethic to privilege children's healthy development means that children and families will continue to struggle.

What I propose is a Marshall Plan for Children's Mental Health (Hoagwood & Kelleher, 2020). Modeled after the economic and social reconstruction effort to restore post-war Europe, this rescue and reform plan will require a fundamental societal shift in American priorities, services and the systems that should be supporting families, children, and youth. It will require substantive federal and state investments in public education, workforce training (importantly including youth and family peer advocates, as well as providers), distillation and dissemination of scientific evidence about effective services, and a measurement infrastructure for monitoring and quality. Some of the pillars of this plan are elaborated below.

The 4 Ds: Deguild, Drive with Data, Distill, Democratize

Deguild and Coordinate

I am referring to three kinds of guilds: service sectors that are administratively bound and often impermeable; professional associations that dictate standards of practice; and mental health models that are medical and therefore pathologize.

- Realign the fragmented sectors within the federal government and within states to reflect the needs of children and families, not the bureaucratic exigencies of administrative units.

- Cross disciplinary coordination should ALWAYS involve youth and family voices. They need to be at every table.

- Cross-disciplinary training should be built into graduate programs (e.g., integrate MAP training into schools of social work)

- Leverage funding from state and federal sources, especially in this post-COVID period, to promote better coordination. NYS example

- Make available free of charge valid and reliable instruments and tools, especially those developed with federal tax dollars, to systems serving children.

- Build research and training curricula in pediatrics, social work, psychology, psychiatry, nursing, mental health etc. to emphasize strengths, not deficits. Young people are celebrating their differences. We need to listen.

Drive with data and accountability

- Develop a full suite of pediatric metrics that promote healthy development for children (i.e., NASEM's Vital Signs for children). These should become as common as blood pressure cuffs. They should be youth and family-driven, and should be promoted and used by health systems and states.

- States and health systems should use evidence-based assessment tools (K-CAT, Top Problems) to create an evidence-based continuum of services that is equitable. These tools need to be built into all community services.

- Integrate evidence-based assessment, case conceptualization, and treatments into EHRs so separate tracking is not necessary

Distill

- Require research reports to include lay-language synopses and distribute them to policy-makers. The burden for this should be on the researchers to know that the work is not done until findings relevant to the public have been disseminated in language that is understandable.

- Expand development of tools that distill evidence into manageable units that can be used by providers (ex: K-CAT, MAP, MDFT)

- Encourage a bigger investment of government funding for technical assistance resource centers to distill research evidence into practical tools

- Embed and disseminate evidence-based assessment tools into primary care, Emergency Departments, clinics, etc. to improve consistency in diagnoses and continuous monitoring

Democratize

- Focus on strengths not pathology in training programs and expand non-traditional workforces by improving training, credentialing, and billing
    - Youth Peer Advocates in every school
    - Family Peer Advocates in every community

    - Family Peer Advocates to focus on helping families gain access to entitlement programs

- Create an Americorps (or similar) program to train, support, and deploy youth peer advocates and support specialists across the country

- Make available psychological first aid training for everyone who interacts with children, including community leaders (and elect them). Require it in medical school training and all school staff. Make it available and accessible to bus drivers, pastors, etc.

- Create a federal coordinating agency within DHHS focused specifically on child, youth and family mental health to prioritize children's health and provide federal leadership to ensure equitable access to high quality services.

- Create coordinating networks of journalists, researchers, advocates, and community leaders to correct misinformation and strengthen collective power (e.g., Maria Ressa How to Stand up to a Dictator example)

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Barbara Huff

Behavioral Health Services Innovation and Adaptation
August 3rd and 4th

In 1988, families identified barriers to receiving services. As of today, many of those barriers still exist. There must be a will to make change occur. Families are no longer willing to keep the status quo.

Educational System

- *Problem Statement:* There is a lack of adequate services and supports for children with mental health needs in schools.

- *Why does this problem continue:* Funding sources are not aligned. There is no consistent method of payment for mental health services in schools.

- *Solution:* Create non-billable payment structures to fund services, such as therapists in schools, to help children with mental health needs.

Individualized Services and Supports

- *Problem Statement:* There is a lack of individually tailored services and support for children with mental health needs and their families.

- *Why does this problem continue:* There has been no will or priority to consistently fund the development, maintenance, or sustainability of services.

- *Solution:* Create a comprehensive, individualized service array that embraces maintaining children in their own homes, communities, and schools.

Advocacy

- *Problem Statement:* There is a lack of any form of meaningful advocacy at the local, state, and national level.

- *Why does this problem continue:* Informed and educated parents are a threat to the status quo.

- *Solution:* Create sustainable funding sources for family organizations, eliminating the headache of constantly chasing funding streams.

Collaboration and Coordination

- *Problem Statement:* There is a lack of collaboration and coordination across agencies.

- *Why does this problem continue:* Agencies are fearful of losing and sharing their resources, assuming it is more difficult and time consuming to build partnerships for collaboration.

- *Solution:* Create and enact legislative mandates at the state and federal levels.

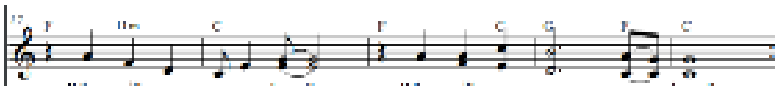
Accountability

- *Problem Statement:* There is a lack of systems accountability.

- *Why does this problem continue:* It is easier to not evaluate. It is perceived to be difficult to change or alter systems based on evaluation results.

- *Solution:* Implement an evaluation structure, ensuring fiscal responsibility and service effectiveness.

Pat Hunt

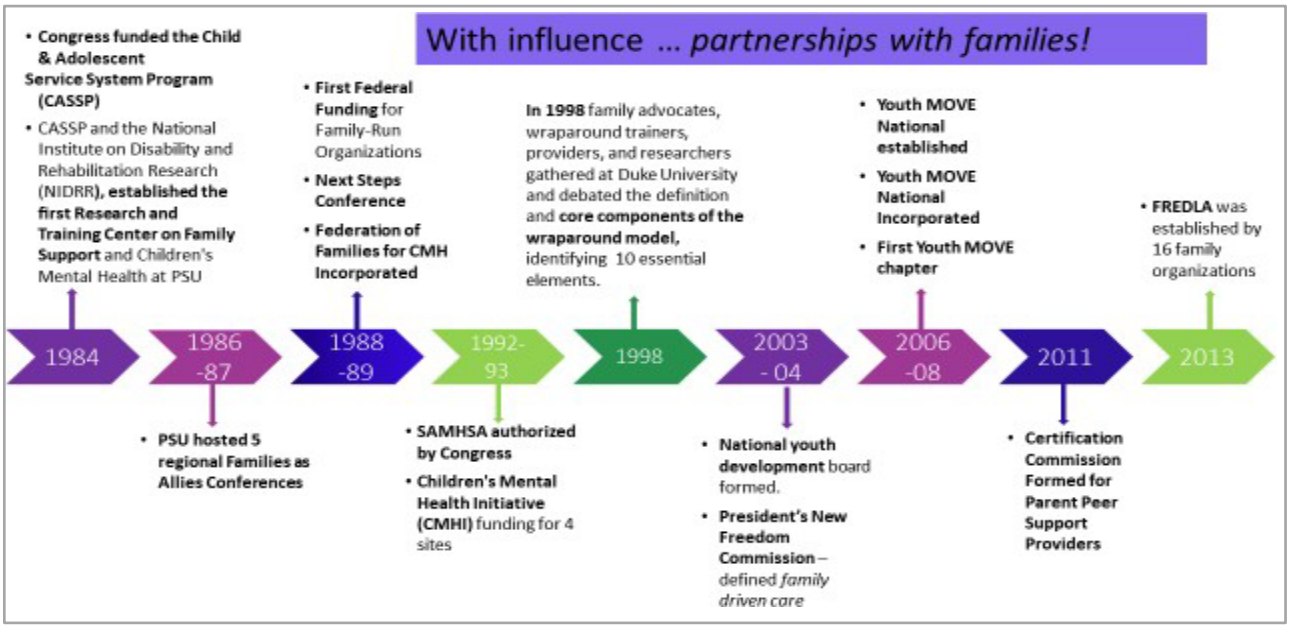


Where Will All the Children Go?

--- when will we ever learn ---

Clearly, our country is at a tipping point regarding mental health services and supports for children, youth, and their families: *the demand outweighs the supply*. The rapid profusion of funds from federal to state coffers during the last few years has not been well thought out on either end. At the federal level, the wash was activated without adequate attention to the capacity of the federal government to both guide and oversee the results of the abundant funding. Loss of historical knowledge, staff turnover, and personal agendas have impacted federal programs to the point where some of their grant management staff do not clearly understand the programs for which they are responsible. At the state level*, those in the know* rushed to the sluices to find enough gold to keep the status quo under a new identity (shifting language to terms prioritized by the funders), or to follow their governor's priorities and dismantle what little infrastructure remained for children's services. This rush was completed with little in the way of planning, readiness to implement, or accountability. While perpetuated by well-intended people, this combination now leaves many families to seek (or demand) highly restrictive and intensive levels of service. Families are desperate and the *supply* is not working.

Over the past 30 years, the Substance Abuse and Mental Health Services Administration (SAMHSA) has established one program after another - many built on a core set of values and principles that rely on the *significant engagement of and direction by* youth and their families. The graphic below reflects the timeline showing that SAMHSA itself was authorized by Congress in part due to the advocacy of a grassroots movement by parents who had four years previously established a national organization.



At SAMHSA, program development for children has reflected a variation of a 'big box store' approach whereby boxes of programs have been developed for particular groups, rather than the broadest possible product mix that serves children, youth, and their families throughout their time of need. Program development and funding for adults these past few years has overshadowed and been at the expense of children as well – which will create a greater population of adults needing more intensive services.

It took 29 years for the SFN grants to move from $20,000 to $120,000 each and the increases in financial support meant fewer of them could be funded. In the past few years, the number of SFN grantees has diminished. There is not one funded in every state to provide the family foundation for engaging families – even though over the past 30+ years researchers cite the positive outcomes of engaging families in care, program design, evaluation, and policy arenas. (https://www.dropbox.com/scl/fi/13ncogqg0bi5dm8kr09vw/Achieving-Positive-Outcomes_from-research-to- reward.pdf?rlkey=5v0v1givvesd932111oph4tnt&dl=0) The chart below provides a picture of funding for some of the SAMHSA programs that have been developed. (Source https://www.samhsa.gov/sites/default/files/samhsa-fy-2024- cj.pdf)

	2020	2021	2022	2023	2024 BR
Statewide Family & Consumer Networks	$4,954,000	$4,970,508	$4,937,200	$4,954,000	$4,954,000
CMHI System of Care	$125,000,000	$125,000,000	$125,000,000	$130,000,000	$225,000,000
Certified Community Behavioral Health Clinics	$200,000,000	$249,249,440	$315,000,000	$385,000,000	$552,500,000
Healthy Transitions	28,951,000	29,451,000	29,433,536	30,451,000	$61,400,000
Project AWARE	$102,001,000	$105,117,728	$119,984,000	$140,001,000	$244,000,000
Project LAUNCH	$23,605,000	$23,508,709	$23,588,200	$25,605,000	$35,408,000
Criminal & JJ Programs	$6,269,000	$6,269,000	$6,252,200	$11,269,000	$56,394,000

The budgets above clearly demonstrate that statewide family networks are languishing (the budget line is for both children and adults). Though not yet employing a design that serves the compelling needs of children and youth, SAMHSA's focus has now become *"across the lifespan"*. Given that over 1/3 of suicides in our country are between the ages of 15 and 35, I submit that the lifespan for youth is indeed short. Children and youth require specialized approaches. Their families are supporting them through a variety of developmental stages, multi-system challenges, environmental conditions, health issues, and disruptions in their lives that no other generation has experienced as a child.

To sum the problem up, a lot of time and money has been spent on organizing and reorganizing by systems funding sources, mental health providers, residential facilities, and others, yet the challenges families faced in 1992 are the very same challenges today (lack of community-based

services, reliance on out-of-home/out-of-state options, custody relinquishment, school-to-prison pipeline, seclusion and restraint – etc.). Old business models continue to rely on illness rather than wellness, and pay for bricks, mortar, and beds. While the programs built on the principles of CASSP have grown in funding and numbers, the very organizations that engage families and help them build their skills are diminishing. The workforce issues in our communities result in more families reaching out to family organizations than ever before.

As a society, we have an obligation to our children. Children must be valued, be supported, be safe, and most of all belong.

The question I pose comes from a Sean Connery character in *The Untouchables*:

"What are (we) prepared to do about it?"

Omaha Meeting Musings

Anne Kuppinger

Families and young people are struggling under the very real weight of so much: poverty, racism, gun violence, dismantling of fragile LGBTQ+ rights, climate crisis, vilification of undocumented people, and, for many, a never-ending treadmill to barely meet basic needs. The chronic stress, trauma and hopelessness that results is a tide against which our efforts to support mental wellness are often not enough.

We can't do our part without acknowledging the context in which we aim to 'do better'. So…Recommendation #1: In whatever capacity we serve, I would argue that we all need to embrace the role of social justice activist along with that of provider, researcher or policy-maker.

The 'bright spots' where folks have access to comprehensive, compassionate, effective care can show us the way, but 1000 points of very bright light is not the same as intentional design of a system that works regardless of zip code, insurance type, or diagnosis. So…Recommendation #2: Let's commit to creating a policy framework and finding opportunities to codify things so that good practice (however we define that) becomes standard practice.

What do I hope we'll continue to work on? Here's my not-so-short, short list:

- Centering the voices of youth, parents/caregivers, people of color, communities
- Improving access to care (shorter waits, right service, no cost)
- Reducing stigma
- Expanding access to evidence informed treatment
- Conducting more research to learn what works best for youth and families of color
- Assertively connecting people to benefit programs
- Creating *real* care coordination
- Pulling out all the stops to support maternal mental health
- Increasing resources to help schools respond effectively
- Broadly replicating progressive approaches in child-welfare and juvenile justice
- Dealing with the cliff experienced by transition age youth, particularly those are are justice involved and who have experienced foster care
- Making long-term investments in workforce: diversify pipelines, staff-informed positive workplace cultures, fair compensation
- Aligning program and fiscal models so good care makes good business sense.
- Expanding access to all types of peer services

A list like this always leaves one with a 'where do we begin' conundrum. So, in the spirit of eating an elephant one bite at a time, while we continue to work on improvements, we need to create the right conditions for people to feel hopeful. Without optimism, many won't seek help at all nor stay connected long enough to benefit. Each individual should write their own equation for what makes them feel hopeful, but in general, I'd say these elements are important: experiencing compassion vs. judgment; receiving timely support from providers who truly

believe that things can get better for you; holistic approaches vs. only clinical mental health treatment; and opportunities to connect and feel less isolated.

One very important path to hope (and better outcomes) is through the incredible work of youth, family and adult peers with lived experience and practical expertise. Imagine that…

- Every new parent struggling with their mental health got the chance to meet with a peer who started the conversation by saying "I so remember being overwhelmed and I felt guilty and worried that I wasn't connecting with my baby. There is a small group of new parents who meet every week and we'd love for you to join us when you are ready."
- Every LGBTQ+ youth who isn't safe at home has a place they know they can call where the youth advocate on the other end of the line says "I know it is hard, but I can tell you it gets better. Let's find a place for you to sleep tonight and maybe we could meet for coffee tomorrow to help you figure out what's next."
- Every parent whose child is hospitalized had the opportunity to talk with a parent advocate who can share a bit of their family's journey and begin to chip away at the disempowering stigma, feeling of failure, fear and isolation.
- A peer-facilitated community team would be created to support every adolescent in/leaving care to wrap them in the support that every young person needs well beyond age 18.

None of this is 'clinical', but all of it is critical. With good peer support, some of these folks won't need traditional clinical services. For those who do, they will be connected sooner and in a way that is a better fit for them because central to the role of peers is to support people to have a voice and engage differently in their care. Peers are critical because of the credibility, mutuality, practicality and empathy they bring to the conversation.

So…Recommendation #3: Expand access to peer services. The planning must be done together with youth, parents and peers – from the beginning, but here is a place to start:

- Regional peer services centers of excellence that can do a variety of things including: training, implementation support, serve as a staffing agency, and provide support to peers in various settings who very likely are working without the benefit of peer colleagues.
- Peer-clinician training teams that can provide both new-hire training and ongoing professional development for peers and the other types of providers who need to fully understand the peer roles.
- Experienced peer supervisors with the time and skills to mentor, supervise, and support the peer workforce.
- Blended funding streams to allow the peer role to include activities not typically funded by Medicaid or other insurance programs (e.g., community-level outreach, advisory roles, true prevention work).
- Compensation, work conditions, and growth opportunities that promote retention.

Robert Lettieri

We have acknowledged the demand and necessity to adjust the mental health system to better fit the needs of individuals across the board. The points below exemplify a portion of the identified problems and potential solutions.

Problems:

1. **Lack of support services**

    - Mental health services across the United States are insufficient despite more than half of Americans (56%) seeking help. 42% of the population saw cost and poor insurance coverage as top barriers for accessing mental health services. 25% of Americans reported having to choose between getting mental health treatment and paying for daily necessities. (National Council for Mental Wellbeing, 2022).
    - Even among individuals with insurance, issues such as lack of available providers, inadequate insurance coverage, high out of pocket costs, and fragmented care persist (Modi, 2022)

2. **Dwindling workforce**

    - Globally, mental health professionals experience wide spread challenges which is shrinking the workforce such as unlivable wages, staff shortage, burnout, inadequate infrastructure, etc.
    - 47% of the US population (158 million people) are living in a mental health workforce shortage area (Saunders, 2023).

3. **Excessive waitlists and inaccessible services due to cost and insurance requirements**

    - The National Council of Mental Wellbeing reports the average wait time to access behavioral health services to be roughly six weeks. For those looks for a specialist, wait times have reported to be over six months (Chamlou, 2022).
    - In the United States, only 36% of psychiatrists accept new Medicaid patients (Saunders, 2023)

Solutions:

1. **Expanded access to peer support services in ***all*** youth and family serving systems**
    - Peer support normalizes natural human responses to unnatural circumstances. Peer support increases hope, acceptance, empathy, and inspiration. It fosters community by increasing social support networks. It decreases symptoms of psychosis and prolonged depressive episodes. It also reduces hospital admission rates and extensive community services.
    - Peer Advocates and Peer Specialists (trained and credentialed providers with personal lived experience navigating systems) have the power to catalyze the healing journey for service recipients. However, too often peers are utilized after a crisis situation has already occurred. If the public had easier access to peers, peer providers could be used as a preventative measure rather than reactive approach. We should be looking at individuals with the notion that they can and will recover; That they will reach a point where they will no longer require services.

2. **Peer led wellness trainings in high schools across the nation**

    - Youth and young adults are statistically more likely to seek support from their peers, rather than from adult professionals. Young people are also seeking the tools needed to form lasting emotional wellness, rather than simply learning medical jargon pertaining to mental illness.
    - By offering young people the adequate training and resources needed to support themselves and others, it does not remove the need for clinicians; it simply adds an additional layer of support. Challenging conversations are happening amongst young people regardless if the professionals are aware or not.

3. **Grow the workforce**

    - Demand for increased wages for human services employees
    - Grow the number of professionals across systems to decrease case loads for individual employees, as well as decrease waitlists for individuals seeking services
    - Create career ladders for mental health professionals
    - Incentivize individuals to earn higher education degrees

4. **Expand access to community drop in centers**

    - Drop in centers have the freedom to offer an array of services without the restrictions of Managed Care/Medicaid. People are aware of the fact that they need help, but it isn't always clear where to go to receive support. It is also daunting and stigmatizing to seek traditional services, not to mention the overwhelming waitlists and insurance prerequisites. We need to create services where individuals can receive trauma informed and culturally responsive support, without the need for insurance. We need to build community resources that foster organic support networks.

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Part 1- The Problem Joe McHugh

"When a society undervalues good plumbing and overvalues bad philosophy, neither its pipes or ideas will hold water."
~ Anon.

Today is May 13, 2023 and Americans of all political persuasions find themselves increasing confused and worried about the state of the world today—and rightfully so. Will artificial intelligence find a cure for cancer or will it destroy the human species—or both? How will governments cope with the mega-storms, drought, wildfires, and impending mass migrations caused by climate change? Will the war in Ukraine lead to a nuclear disaster? Will the wealth gap between rich and poor bring about social upheaval, possibly violent revolution? How can the scourge of drug addiction be stopped? How many more mass shootings will it take before we restrict the purchase and use of assault weapons? Is the banking system on the brink of collapse—what about with the health care system? Will deep fake technology undermine trust in media and the democratic process? Will the government default on its debt and, if so, what will happen to those who depend upon disability, Social Security, and Medicare benefits, not to mention those who work for the government, sell products and services to the government, or work for social welfare and cultural agencies that rely upon government funding to keep their doors open?

Okay, now that we're sufficiently freaked out, let's consider for a moment how this confusion and worry might be affecting our children? I grew up in the 1950s and 1960s when most adults believed children went around in a state of blissful ignorance when it came to the stresses, conflicts, and depressions affecting the adults in their lives, their parents, teachers, relatives, and other caregivers. Research in the field of brain and mind development of young children in recent years, however, has debunked this belief. Children may lack the language skills to express how these influences are impacting their mental health but impact that health they surely do. In fact, I often think that, given all the confused signals we impart to our children on both an individual and societal level, children do far better managing their mental health than we should expect. Why is that?

Perhaps it is because, as a wise man once observed, "There are only two things that endure: old trees and the innocence of children."

All the same, I greatly fear the assault upon childhood innocence by what I call the Storytelling Industrial Complex has reached the point that it may well destroy that innocence by degrading and/or perverting the powers of the imagination.

That, of course, begs the question: what do we mean when we use the word "innocence?" What do we mean when we use the word "imagination?" Come to that, what do we mean when we use the word "mind," since we're talking about the mental health of children? Are the "brain" and the "mind," more or less the same thing? Many people believe that the mind is merely a projection created by a series of electrical and chemical reactions taking place within the mass of neural cells residing inside our skulls and those that cluster about our

major organs. Recent research in the field, however, demonstrates that the mind has the power, under certain circumstances, to alter the physical structure of the brain leaving us with a variation of the chicken and egg conundrum I suspect.

Returning to the idea of the imagination, I find it useful to compare this internal function of the brain/mind to a farmer's field. The imagination is soil from which we grow our nighttime dreams. We know from extensive sleep research that if you prevent someone from dreaming by waking them as soon as they display rapid-eye-movement, it won't be long at all, only a few days in fact, before that person becomes psychotic. We may not know exactly why we dream but we do know that it is vital to our mental health that we do so. And other crops grow in our field of the imagination besides nighttime dreams. From this rich interior soil spring forth our erotic fantasies, idle daydreams, bursts of artistic inspiration, moments of creative problem-solving, even religious raptures—a veritable cornucopia of what the ancients called "enchantments."

But if the farmer overloads the soil of his field with high-intensity, industrial-manufactured fertilizers to increase his yields he runs a very real risk of exhausting that soil over time. The soil of his field does need to be regularly fertilized, as does our imagination, but it should be done in a sustainable manner.

Today we are pumping into the interior realm of the imagination a great quantity of high-intensity, electronically-generated, non-sustainable stimulation in the form of films, television shows, music, advertising, computer games tweets, text messages, breaking news, tiktok challenges, political campaign rallies, sporting events—and now various forms of AI—with the result that we are exhausting our collective imagination and this exhaustion, I believe, prevents us from coming to terms with the existential threats we face as societies and more generally as a species. How can we grow the creative solutions and unifying mythology from soil that is bombarded nearly every second with such intense stimulation? And what is this stimulation doing to our children? The issue is not whether a particular unit of stimulation is good or bad, although that might matter at the micro level, at the macro level, it is the sheer mass of electronic stimulation that is overwhelming our carbon-based cognitive abilities to handle whether young or old.

Part 2- Solutions

This is such a large and important topic but given the restraint of word count I will put forward two ideas that are very much related.

We should seek ways to reduce the exposure electronic media is having on our children by providing them with opportunities to fertilize their imaginations in sustainable ways. There are so many activities that replenish the imagination without overwhelming it: listening to stories, telling stories, sleeping out at night under the stars, gardening, canoeing, pick-up games of baseball and touch football, painting, playing music, reading a book, going for a walk in the woods, sewing, cooking—well, you get the idea. It is a very long list and as old as humankind itself. A healthy fertile imagination, I believe, is essential to their continued mental health and powers of resiliency.

Dr. David Kessler who served as commissioner of the FDA wrote a book that he titled *Capture*. After looking at current brain and mind research, he puts forward the idea with numerous case studies that human beings are designed to be captured. The idea that we can be free of all capture "mechanisms," he believes is a fallacy. Like Bob Dylan says in one of his songs, "You've got to serve somebody."

The task then, as I see it, is to be captured by something that has a positive effect on one's life. Drugs, gambling, sex, alcohol, eating disorders, tobacco, violence, shopping, extreme political partisanship, conspiracy theories, avarice, religious fundamentalism—even excessive exercising, often produce negative consequences for the person so captured and often for others as well. This is where I believe adults can be of the greatest service to young people. They can introduce young people through direct experience, and that's the key, to activities and belief systems that can capture them in life-affirming ways, that might even provide the young person with that most essential of all human needs: joy and an abiding sense of meaning. These are the blessing so many of us yearn for in our own lives. Are they not what our children yearn for as well? They also need joy and a sense of meaning to make it through the ups and downs of life and they look to us for guidance, patience, and faith in this quest.

"Under certain conditions, intimidation without gentleness may achieve something momentarily, but not for all time. When, on the other hand, the hearts of men are won by friendliness, they are led to take all hardships upon themselves willingly, and if need be will not shun death itself, so great is the power of joy over men."

I-Ching - Wilhelm Translation, 1950- Princeton University Press

Mental Health Services and Services Research:
Time to Reflect, Re-examine, and Rethink
William E. Reay, Ph.D., Omni Inventive Care

Over the past several decades the children's behavioral health system experienced a host of initiatives including the elevation of parental involvement in the care of their children; a value-based system-of-care philosophical initiative aimed at creating a common set of values for service development and delivery; school-based behavioral health service development; and the advancement of empirically based treatment. These initiatives created an environment for other important initiatives including information transfer science; methodological advancements in evaluating services; and training programs designed to bring the applied science to every day practice. In many respects, these initiatives were and remain attempts to redesign the architecture of services; address funding mechanisms, inform training programs, and influence politics. Clearly, all of these initiatives are aimed at changing professional practice and influencing known social conditions associated with improving the lives of children with serious behavioral health problems and the lives of families.

By no small measure, these initiatives were a response to the writings of authors like Jane Knitzer and Ira Schwartz. These authors underscored the reality that children were receiving inhumane care; languishing in institutional settings; not improving in important areas of everyday functioning; and parents were marginalized and blamed for their children's behavioral, emotional, and mental health problems. Important scholarship by professionals like Barbara Burns, Gary Melton, Leonard Bickman, and Allan Kazdin, advocated for alternatives to institutionalization and called for the development of effective behavioral health treatments for children and families, including the development of supportive neighborhoods and schools and systems that could sustain envisioned improvements.

Fortunately, some of us have been involved in these movements since the early 1980s, and have remained as both consumers and contributors to the emerging science. Arguably, some improvements have been made in the lives of some youth and some families. However, for many families, the envisioned promise of easy access to effective mental health care, living in supportive communities, and attending schools that are sensitive and responsive to the needs of parents and children with serious mental health conditions remains unfulfilled.

The challenges to the future of mental health services for children and families remain relatively unchanged over the past 3 decades. The field struggles with relevancy and our science remains defined by a series of demonstrations and pilots; none of which gain sufficient empirical, political or social support to sustain wide scale acceptance. Without such acceptance, meaningful sustainability is impossible. Research methods including model designs remain inflexible and infidelity to models has become one more reason to blame parents, youth and providers for multilevel failures. Consequently, funding bodies find little reason to see differentiation between treatments or providers and have relegated our craft to an economic model best described as a commodity. This failure has inadvertently assisted political leaders in understanding mental health services as discrete units. This degrading of public trust in our profession is one of the most significant challenges to the future of mental or behavioral health services, and break-through behavioral health services research.

As a legally trained psychologist, who has spent over 30 years as an organizational executive; academic researcher; expert witness in controverted mental health cases, and program architect of evidence-based treatments, I have lived through many of these behavioral health initiatives. As an "early adopter" of various evidence-based treatments and other technological and methodological

advancements; and proponent of using information transfer science in training young professionals, I have also adopted and accommodated treatments and scientific results to different populations and environments. I have also been responsible to various funding bodies in an attempt to demonstrate "service worth" regardless of how those funding sources view the applied research. Those experiences have led me to several conclusions about the future of mental health services. I have identified the following areas which need to be addressed:

Commoditization- Our service products, including those responsible for delivering those products have been subject to commoditization. This is not unique to mental health, other services to children have also been commoditized. The social and economic worth of mental health services remain virtually the same as it has been understood for decades. Mental health treatment remains conceptualized by setting of service, not the actual treatment delivered. In other words, there is virtually no agreement within the profession that the delivery of service must separate setting of service; treatment(s) of the conditions; vehicles of delivery (people); supervision, surveillance, monitoring, and feedback regarding the effects of the treatment.

Academic Training- Beyond a few research oriented programs, graduate education programs have not adjusted core training to produce an adequately prepared workforce. Ann Garland highlighted that the vast majority of mental health service delivery is provided by less than terminally degreed professionals. There has been very little attention paid to how to get this workforce trained in effective mental health treatments. As highlighted by Alan Kazdin, the problem with implementation is formidable.

Law and Psychology- There are very effective legal strategies that can be used to advance the use of effective mental health treatments. The judicial branch of government at every level can and will, given certain circumstances, advance evidence-based treatments and the development of an adequately trained and supported workforce. Several behavioral health practitioners and research scientists have experience in taking advantage of these circumstances, but their contributions have largely gone unharvested, e.g., Bruce Chorpitia's work in Hawaii, and Len Bickman's work in North Carolina. Although these individuals capitalized through their individual efforts, insufficient analysis of the psycho-legal environments that led to their opportunities. The intersection between ripe legal conditions that could be used to promote or advance the use of evidence-based treatments should be investigated. Similarly, consent decrees, and the advancements that were made possible by the involvement of the United States Department of Justice have not received the retrospective analysis that could lead to a better understanding of how mental health leaders and scholars can take advantage of situations that are "ripe" or ready for policy, practice, and research advancements.

Error Analysis- Unlike most every other industry, the mental health services industry does not analyze *system/research-to-practice failures*. Failed initiatives seem to just lose favor, much like a social or political fad. Analyzing failures, from a systems perspective allows scientists and program architects to begin the process of building models associated with various levels of failure. For example, some of the EBPs are seen as complicated to implement at the provider level. Assumptive arguments provided by mental health service researchers place relatively high importance on "fidelity" but rarely provide a detailed analysis related to the reasons for that failure beyond the individual practitioner or organizational culture. However, comprehensive error or failure analysis needs to include the relative contributions to many factors associated with that failure. *Reason's Model of Error Analysis* would be a good starting point.

Market Disrupters- Learn from service entrepreneurs and *market disrupters*. Entrepreneurs and market disruptors are more than mere risk takers. Results from economic science research indicate a much more complex picture of these professionals. They tend to have a high tolerance for ambiguity, and look for areas to push for rule expansion. These leaders tend to see opportunities for

application and innovation where others do not. They also tend to see both external and internal barriers to goal attainment far more clearly than other more traditional leaders, and build relationships aimed at assisting them in their goal attainment. Moreover, they tend to also market their successes in ways other do not.

The Lasting Social Narrative about the Troubling, Troubled, and the Poor. The United States government and business communities have been trying to design social strategies to manage the troubled, troubling and poor for more than two centuries. The social conditions which prompted the "post-Jane Knitzer" period need to be understood in terms of the larger social context and the understandings and beliefs which needed to be reformed at that time. However, it is important to understand how our long-standing social attitudes toward certain groups within our country drive how we, as academics and mental health professionals respond to those who provide the narrative about the target groups of poor, troubled, and troubling. In other words, the social politics that drive our research questions, influence our metrics and ultimately our service response.

Toward a Unified Model of Behavioral Health Services, Training, and Research-The above-mentioned problems are interrelated. A new inclusive model needs to be developed. This model must be driven not only by quality research, but by a full appreciation of the challenges and tragedies experienced by those with various presentations of mental illnesses. Academic training programs need to jettison the *scientist-practitioner* model of graduate training. This "Boulder Model" was built in 1944 and supported under specific social conditions that do not reflect the social complexion of 2023 or who delivers mental health services. Today, the vast majority of mental health service is being delivered by non-terminally degreed persons; a delivery system that was not anticipated when the scientist-practitioner model was adopted, and there has not been any attempt to meaningfully adapt the model to non-PhD/PsyD persons.

The *Research-to-Practice* Model of [academic] training would be more expansive to include the applied and theoretical research related to consumer perspective(s) and on implementing evidence-based treatments, adapted to the ongoing challenges that face young parents, professionals and non-professionals experience. The model would train in community-based care for those individuals with chronic, multi co-morbid disorders, including "wicked problems," as well as increasing the number of culturally and ethically diverse lay and specialist providers trained to provide evidence-based services.

There is a cultural crisis in mental health literacy and competency in the United States. This illiteracy is similar to other historic crises this country has experienced. Although presenting as a mental health crisis, the problem may lie in the unsuccessful transmission of rudimentary non-critical and non-professional skills necessary to navigate critical requirements of the social context of everyday life. The remedy needs to be tied to an economic model that includes a mental health ideology that teaches children to master complex social, interpersonal, cognitive, and emotional demands.

This functional illiteracy of mental health became more visible as a consequence of the pandemic and shifts in both economic and social conditions, e.g., disruptions with formal schooling, online education, and the increased dependency of social media. Becoming mental health literate involves the reconstruction of the mental health experiences of becoming literate, viewed within the larger context of sociocultural ideologies within which mental health elements are embedded. The question becomes how to identify, describe, and transfer those "mental health artifacts" in a manner that children at any developmental level can acquire those discrete characteristics. Central to that consideration is how it becomes organized in culture-specific ways according to certain norms, and how it gets transmitted.

Problem and Solution Statement for OMNI Inventive Care

Richard Wiener, PhD.

Expertise Statement. The expertise that I bring to this discussion is that of a program evaluator and applied researcher working mainly in the area of juvenile justice with occasional forays into the adult system (e.g., problem solving courts and adult probation). I have experience studying the effects of interventions in juvenile justice at the state and local levels and have found. like so many others, that behavioral health and criminogenic needs almost always co-occur, so that treating one set of needs more often than not influences the other. My comments arise out of my experience doing this work in the field and in my understanding of the literature in law and psychology and program evaluation, areas to which I have made some contributions.

Problem Statement: The field is in possession of a number of interventions that work reasonably well to resolve some of the behavioral health problems that culminate in youth and adults slipping into the juvenile justice, and then later, the criminal justice systems. In fact, in recent years, meta-analytic studies have shown good success for interventions that target both juveniles and adults, when they follow the Risk-Need-Responsivity model that Andrews et al. 1990 and colleagues (Bonta & Andrews, 2017) developed over the last several decades. The model requires that efforts to assist juveniles and adults embroiled in the justice system adhere, first and foremost, to the risk principle, which requires that intervention and service delivery correspond to the level of risk that offenders pose for continued criminal activity. The RNR model also relies on the need principle, so that interventions and services should address the criminogenic factors that drive unlawful conduct and the responsivity principle, which recommends that interventions and services fit the motivational, emotional, and cognitive characteristics of individual (Bonta & Andrews, 2017).

The problem, as I see it, is the failure of interventions to adhere to the RNR model and instead to follow the unguided discretion of well-meaning probation officers, mental health practitioners, and administrators who act with good intentions but operate mostly out of their subjective intuition. They sometimes administer, but still fail to rely on valid screening and assessment tools, they apply interventions that are unproven without benefit of rigorous evaluation, and they do so using a one size fits all approach that ignores the responsivity of the individuals involved. In my experience, even when using evidence-based interventions, interveners implement the programs in ways that are inconsistent with the tested procedures that have been shown to bring about change. Probation officers, social workers, and mental health practitioners want to be creative and innovative, and as a result to discover new and better modifications of data-based techniques. They knit together pieces of multiple interventions to create their own "treatment soup" which dilutes the effectiveness of the original proven interventions. Thus, the failures of the system to intervene and ameliorate behavioral health problems, at least enough to lower recidivism, improve quality of life, and reduce justice expenditures is in large part due to the failure to adopt evidence-based practice interventions and *consistently* implement them as intended.

In my experience, the reasons for this failure occur at multiple levels of the service provider environment. At the "higher" levels of decision making are administers that do not understand

the roles of clinical staff, correctional staff, and evaluators and as a result are unable or unwilling to facilitate the consistent use of evidence-based interventions because of political and economic pressure. Administrators are too frequently uninterested in documenting implementation processes and instead hang their hats on poorly measured and poorly conceptualized outcomes. In fact, the lack of understanding by administrators (and here I include agency directors, judges, and local politicians) of basic scientific method causes them to misinterpret data to support interventions that do not work. At the same time at the "lower" levels of the system are providers who, "in their hearts" believe more in the life coach role than in the proven best practices that have been shown to work in the research literature. In short, it is more enjoyable to be creative and experiment with innovative strategies than to apply the same old techniques in a consistent manner. Thus, in my view, the major sources of system failure are the lack of knowledge of evidence-based practices, political pressure to ignore mundane interventions, economic pressure to abandon evidence-based efforts, and the lack of motivation to implement interventions in a consistent manner.

Solution Statement. My solution statement focuses on juveniles rather than adults because my own expertise about potential solutions is better situated in the juvenile justice system. I have been, and continue to be, impressed with Lipsey's ground backing work in 2009, in which he reported a meta-analysis of 548 independent study samples from 361 research reports between 1958 and 2002. It demonstrated programs that work to reduce recidivism largely by addressing behavioral health needs and retraining youth through CBT techniques to think about the world in more positive and productive ways (i.e., through counseling, multiple services, skill building and restoration). Perhaps, most importantly, the quality of implementation and not level of provider training was the most important ingredient in successful models. Significantly, the analysis showed that "brand name" interventions were no more successful in reducing recidivism than were locally designed interventions provided that they were evidence-based and were implemented consistently as originally developed and successfully tested.

This brings me to my second point, namely the importance of taking a community perspective to resolving behavioral health problems. When I was a graduate student, Julian Rappaport's ideas about the role of community in addressing behavioral health problems in youth and adults was at the forefront of a reform effort to modify the scientist practitioner model (see Rappaport, 1987; Rappaport & Seidman, 2000). The approach emphasized the need for multilevel theory and intervention, a focus on collaboration and resource development in the community, seeking out the strengths in those suffering from behavioral health problems, and seeking out the strengths to be found in the communities that supported them. The focus was to train and utilize community members to deliver badly needed services to often impoverished minority communities. The old "community psychology" fits well with the modern evidence-based literature that shows how we can train parents, peers, and community members to use cognitive behavioral approaches and implement them consistently. While this is not a new idea, it remains, in my view, the most viable approach to resolving the "treatment gap", or the fact that in the United States many children, adolescents, and adults who are in need behavioral health services go without (Kazdin, 2021). I believe that training peers, community members, and lay providers to deliver trauma informed, state of the science, and evidence-based interventions in the context of the community offers the solution most likely to be effective.

How should this be done? Implementation science points the way by advocating the application of treatment technologies identified in rigorous evaluation studies, efforts which themselves lead to rigorous empirical studies of how to best execute evidence based behavioral healthcare in the juvenile and criminal justice systems (Wenseing, et al., 2021). The process includes instituting and monitoring empirically validated interventions, technologies, and policies in the community and de-implementing practices and procedures that are of low or no benefit to the youth and adults that they are designed to help. In my mind, this is an application of the early community psychology efforts aimed at helping people in impoverished communities to become service providers for youth, adults and families and thereby helping them to lead healthy and productive lives. It is no surprise that impoverished communities with large numbers of disenfranchised and isolated individuals are at the highest risk for debilitating behavioral health problems. The focus should be in the communities with the greatest need.

This returns me to the RNR model and especially the issue of responsivity. We have learned over the last several decades that the best approach to treatment is one that focuses on fitting the services provided to the individual needs of the service recipients. With respect to the juvenile system, Cavanagh, Paruk, and Grisso (2022) wrote a summary piece showing that since the "get tough on crime" period of the 1980's and 1990's, the advancement of a developmental perspective, which differentiates adolescent and adult needs has revolutionized the care that the juvenile justice system offers to children and youth. They argue that to the extent that we have realized success it is because service providers acknowledge and indeed design interventions that adhere to that developmental perspective. The paper analyzes the changes in assessment, intervention, and policy that resulted from the acceptance of this developmental perspective and proposes the path forward is one that continues adhering to the "responsivity" factor of the RNR model. Cavanaugh et al. (2022) identify a number of salient threats to the developmental reform movement (e.g., public safety concerns, insufficient cultural acceptance, and fragmented efforts) and offer some remedies that experts agree will be helpful to sustain the movement toward responsivity (i.e., leadership training, sustaining connections, and giving youth and families voice). While the Cavanaugh et al. (2022) paper focuses on responsivity of youth in the juvenile justice system, similar efforts toward developing responsivity for treating adult behavioral health problems could be equally as effective and could be one of the most important outcomes of the OMNI conference.

To summarize my view as a program evaluator working largely in the juvenile and criminal justice system, I advocate a cyclic model (Rossi, Lipsey, & Henry, 2019) that features individualized needs assessments in community context, training community peers to offer evidence based interventions in ways that show fidelity to the original model and that are responsive to the targets of the intervention, carefully monitoring the implementation of the interventions, documenting outcomes, and then modifying the process with what is learned from the implementation and outcome studies. These are my ideas, which admittedly are rooted in an evaluation perspective. Therefore, I'm very interested in hearing what others attending this conference have to say about the problems in and solutions to the delivery of effective behavioral health services from their own points of view.

Omni Meeting Issues Brief

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The strength of a society is based on the values on which that society is built. The degree to which that society survives and thrives depends on how those values are supported and defended. A society is, in a sense, a collective family, made up of many smaller families. Unfortunately, many internal and external factors have impacted families to the extent that child and family serving systems have been unable to adequately meet their needs, with children and youth paying a high price.

Training Programs: Academic institutions unfortunately turn out mental health and social service graduates who are not sufficiently trained to enter the workforce. Students frequently do not understand the types and needs of individuals they will be serving and they do not know how to complete basic service activities. Nor are they prepared for the work environment and the challenges they may face. As an employer and clinical supervisor, it was left to us to support them through the culture shock and train them to do the job. Professional training programs need to adjust curriculum to educate students on trauma, evidence-based practices, documentation, self-care, professional ethics, and how to survive in the changing workplace.

Service Capacity: Over the years, there have been numerous initiatives designed to develop service capacity to meet the complex needs of children, youth and families. The CMHS System of Care is one such initiative. A great deal of federal funding was funneled into the System of Care movement, which was designed to expand and integrate formal and informal services and supports, with a strong emphasis on elevating the voice of youth and families into the planning, delivery and evaluation of services. Flexible funding was available to assist with basic needs. In many cases, these programs demonstrated value and effectiveness, but were not sustained after the grant period ended, as child serving systems just returned to previous ways of serving children and families. Many pilot and demonstration projects have not been sustained or expanded due to lack of evidence of program effectiveness or lack of commitment by policy makers to support the programs or dedicate funding.

Service capacity development too frequently depends on “what the Feds will pay for” rather than what communities need. Federal funding is all too often funneled to certain services, and these are the services that get developed, often leading to significant duplication. Medication Assisted Treatment is one example. For a period, the major focus of service development was to expand MAT for opioid misuse. Because that was where the money was, providers who previously did no behavioral health services went into the MAT business, with varying degrees of effectiveness and contributed to workforce shortage. Expansion of MAT was certainly needed, but in many cases this expansion was unevenly developed, with rural areas lacking because it was more difficult to develop services in rural areas. Fortunately, the expansion of telehealth because of the COVID pandemic has addressed access to services in rural areas.

State funding frequently follows the same path, since much of their funding comes from SAMHSA. Because the needs of children, youth and families are diverse, the service system that supports them must be diverse as well. A system of care that swings like a pendulum, cannot be expected to adequately serve and support.

Siloed Systems: Troubled children, youth and families frequently become involved with multiple systems, including education, child welfare, behavioral health, courts, juvenile justice, law enforcement, etc. These systems often do not work in concert with each other, and decision-making is often accomplished in siloed fashion. Siloed systems create untold challenges for families. These systems frequently have competing demands and yet families are expected to navigate and meet the demands of all of these systems. Siloed systems require children and families to tell their stories over and over, pose problems coordinating services and supports, and leave families frustrated, overwhelmed, and may contribute to lack of trust and disengagement. When this happens, the family usually gets the blame. Certainly efforts are made to ensure coordination of care, but this is not the same as care integration.

Systemic Bias, Racism, and Stigma: Working with communities across the county, one common problem identified is stigma. Stigma takes many forms but is evident in the way individuals with mental health or substance use problems are viewed by communities. Stigma is also evident in how youth with mental health or behavioral problems are viewed. Individuals and systems also have implicit bias that can greatly impact access to quality services and supports. In WV, there was resistance and even refusal by many child welfare workers and judges to return children to parents who were on MAT. Fortunately, a great deal of education has reduced this bias, but we are not there yet. Bias, stigma and racism lead to discrimination and inequities in Social Determinants of Health that result in negative outcomes for children, youth, and families.

Impact of System Policies: All child and family serving systems and organization have policies that are designed to establish protocols and procedures for how their services are provided. However well intended these may be, there are times when these create system-induced trauma. This can be seen clearly in the out-of-home placement of children. The sudden and unplanned removal of children from their families without children even getting to say goodbye or not knowing when they will see their families again; placing children in hospitals, residential centers, shelters. or foster care; moving children from their communities and schools; multiple placements; or moving children to new placements without the benefit of being told beforehand or having the opportunity for transitioning can all cause additional and equally damaging trauma. Another example of the impact of system policies getting in the way of services is the hesitancy of parents to seek services for a substance use disorder out of fear that their children will be removed. This is not an unrealistic fear.

Policies should be developed to provide structure and guidance for how services will be provided, but they need to be written with a sensitivity to how they impact clients. Policies that are designed for the convenience of the provider or system without consideration for how they affect clients and individuals serve need to be reviewed.

Funding: Funding for services will always be contentious and there will always be disagreement about what should be funded and at what level. Despite the emphasis on collaboration from federal, state, local and organizational levels, when it comes to sharing funding, walls go up. Some states have used Medicaid funding, particularly in expansion states, to fund a variety of services not historically covered due to not meeting “medical necessity”. States have benefited from changing State Medicaid plans and applying for 1115 waivers to fund needed services.

Other funding issues are unfunded mandates and a lack of parity between reimbursement for physical health and mental health services, including type of provider and restrictions of place of service reimbursement. Although parity between physical and behavioral health services has for service reimbursement has improved, the medical necessity criteria and documentation requirements continue to be challenging.

An example of unfunded mandates are service requirements and licensing regulations that increase the cost of services or are expensive to meet and don't really impact the care of individuals, but reimbursement rates are not adjusted to cover the costs.

Funding parity inequities continue in many states. In WV and in states, behavioral health services provided by Community Behavioral Health Centers/Certified Community Behavioral Health Centers and FQHCs are not reimbursed at the same rates for Medicaid. FQHCs are funded through cost-based rates while CBHCs are not. This has created a lopsided reimbursement system and has resulted in FQHCs successfully raiding CBHCs for licensed mental health professionals, as they can afford to pay significantly higher salaries. Another example of funding parity issues related to place of service. In WV, insurance companies reimburse for mental health services provided at a clinic setting, but will not pay for mental health services provided in schools (with the exception of those provided in school-based health centers).