

TRANSFORMING PHILADELPHIA'S CHILD-SERVING SYSTEMS:

*A Call to Action
for the
Department of Behavioral Health and
Mental Retardation Services
City of Philadelphia*

Prepared by



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GUIDING PRINCIPLES

We envision a resilient and recovery based behavioral health system for children and families - one that incorporates the core values of hope, optimism and a positive outlook toward the future. The guiding principles of a resilience and recovery based system of care must drive reform of behavioral health services.

The following principles guided the development of this Call to Action and should inform further implementation efforts:

1. Resilience and Recovery- both which are based on the core values of hope, optimism and positive orientation toward the future.
2. Services for children and youth must embrace the Pennsylvania Child and Adolescent Service System Program (CASSP) Principles.¹ The CASSP principles are as follows:
 - i. *Child-centered.* Tailored to each child’s strengths and needs and developmentally appropriate.
 - ii. *Family-focused.* Family participation and full partnership is encouraged and developed at all levels of treatment and planning.
 - iii. *Community-based.* Services are delivered where the child and family live in order to make full use of informal and formal supports.
 - iv. *Multi-system.* Improvements in service delivery require a cross-system approach placing the needs of children and families first.²
 - v. *Culturally Competent.* Services must recognize and

respect the culture and values of each family and its members.

- vi. *Least restrictive/least intrusive.* Delivery of services takes place in the most natural setting possible for the child in order to foster resiliency- recovery and avoid barriers to community integration.
3. Prevention and Early Intervention should be cornerstones of the service delivery system and not an afterthought when “additional” funding is available.
4. A health and wellness perspective should govern the approach to interventions for youth and families such that the co-occurrence of medical and mental health problems does not compromise treatment. A wellness perspective embraces prevention and early intervention programming as key roles in service delivery.
5. Behavioral Health Services must be integrative within a continuum of care with respect to mental health and addiction assessments and interventions.
6. Behavioral Health Services must be developmentally appropriate across the lifespan.
7. Evidence-based practices should be aggressively adopted, implemented, and evaluated for local application.
8. Program evaluation should be an integral part of service delivery such that a local “best practices” evidence base develops.
9. Youth and families are involved in all aspects of service system design, evaluation, and governance since they are partners in their journey to wellness.

¹ Pennsylvania CASSP Training and Technical Assistance Institute, Center for Community Action and Research of Behavioral Sciences and Education at Penn State University in Harrisburg, Pennsylvania.

² While this A Call to Action specifically addresses the behavioral health system, we expect DBH/MRS will strengthen cooperation with the other major child-serving systems in the city including education, child welfare and juvenile justice.

EXECUTIVE SUMMARY

The time has come to transform child-serving systems in Philadelphia. Over the years, we have witnessed numerous planning efforts by system stakeholders resulting in consensus to substantially transform the types of services offered to youth and families as well as the manner in which the system operates. Cross-systems dialogue produced areas of agreement on what our child-serving system could become and highlighted shortfalls in the present behavioral health service delivery system for youth and families.

We call for the leadership in the City of Philadelphia's Department of Behavioral Health and Mental Retardation Services (DBH/MRS) to act boldly and decisively to improve the quality of life for youth and families struggling with behavioral health issues.

The following six "Required Actions" will put Philadelphia on the path toward meeting the behavioral health needs of young people and their families. These recommended steps are consistent with areas of concern that have achieved high consensus among stakeholders. We urge DBH/MRS to act on these required actions without delay.

We call on DBH/MRS to implement these Required Actions by January 2007:

1. Provide trained behavioral health staff on-site in no less than three neighborhood health centers with the capacity to provide evidence-based care and evaluate program as well as individual outcomes.

Rationale: Research indicates many families do not access support services through traditional medical models. Wellness-including physical, mental, social, emotional, and spiritual health- should be promoted. Communities must be empowered, educated and guided to support children coping with mental health challenges in ways that are comfortable and accessible.

Goal: *create more flexible, community-based, family driven services by integrating behavioral health services in the*

primary care settings of local neighborhood health centers.

2. Introduce a Peer Specialist component integrated into all Wraparound services and place Peer Specialists in a minimum of five existing community youth programs for children and families.

Rationale: Peer interventions are critical for advancing a resiliency and recovery oriented system of care. Peer Specialist in the child-serving system must be defined to implement a model that can be used in Wraparound services as well as neighborhood programs that youth and families frequent. There will likely be a need for different types of youth and family peer specialists but the essential component should be shared experience with behavioral health issues. Some peer functions for youth may be served by age peers whereas others will require adult mentors.

Goal: *Refocus community Wraparound services and incorporate Peer Specialist support for children and adolescents.*

3. Have a minimum of three community-based respite care providers, one less formal network of families who provide respite care, and establish drop-in respite for youth in partnership with three community groups (e.g. respite for youth who need informal opportunities to interact with others).

Rationale: Respite services must be creatively expanded to address the diverse and changing needs of families and youth. Respite is essential for shifting the system toward a greater focus on prevention and early intervention. A network of providers who openly assist families by providing respite along a continuum must be developed—as a model for recovery, prevention, and crisis intervention- so that children can remain in their communities and family stability is strengthened. Care should be provided by agencies as well as less formal networks of families who receive appropriate supports for helping others.

Goal: Design and implement a continuum of respite care services for youth and their families.

4. Identify all youth in the shelter system and deliver appropriate mobile services to them and their families. Follow these families with appropriate services and outcome evaluations until permanent housing has been achieved and maintained for at least one year.

Rationale: We must consider the behavioral health needs of children who are displaced with their caregivers. The lack of affordable housing and involvement in the shelter system results in inconsistent behavioral health treatment and services for children. Mobile support services can travel to various sites around the city providing a range of services to homeless children.

Goal: Deliver a continuum of mobile treatment and support services to children and families who are homeless and work toward eliminating placement of youth in the shelter system.

5. Identify all youth in the behavioral health system between the ages of 16 and 21, and deliver appropriate support across all life domains through individualized Transition Teams.

Rationale: Adolescence and young adulthood is a critical period in human development. While there is opportunity to set the stage for success in adulthood, there is the risk of poor life outcomes if the foundation is not solid. The key to successful transition is to start early and have skilled behavioral health specialists guide youth toward a future focus. Transition teams will provide youth planning, peer support and mentoring, and school re-entry support following these youth for a full year after their successful transition to the least restrictive environment.

Goal: Deliver flexible, cross-system, mobile supports and services to all transitioning youth receiving behavioral health services and assist youth to become

productive, capable adults in their communities. It is crucial that youth are equipped with skills, treatment options, and support services in preparation for care provided by the adult behavioral health system.

6. Have trained trauma-informed Peer Specialists, Mobile Support Services, and staff in a minimum of three neighborhood health centers providing behavioral health services.

Rationale: Trauma-informed services must be implemented throughout the continuum of care for children, adolescents and families. Trauma is an unfortunate reality for our youth and in order to address the special needs of these children in ways that will promote resiliency and recovery, trauma-informed services must be infused throughout the child-serving systems. We must assess the impact of our interventions to plan for the full implementation of trauma-informed services in the children's system based on our needs as well as research from other communities.

Goal: Develop and implement trauma-informed services for children and families in the child-serving systems by partnering with national experts to design a trauma-informed system of care.

INTRODUCTION

It is time that we, as a Nation, took seriously the task of preventing mental health problems and treating mental illnesses in youth”

-David Satcher, MD., U.S. Surgeon General, U.S. Public Health Service, 2000

The time has come to transform child-serving systems in Philadelphia. Over the years, the Department of Behavioral Health and Mental Retardation Services (DBH/MRS) in Philadelphia has made consistent reform efforts by updating its strategic plan for improving behavioral health services for children and adolescents.³ Many stakeholder groups have brainstormed and identified problems and needs and suggested changes. In fact, several state and local plans for system change by various stakeholders have been developed.⁴

The previous strategic planning of DBH/MRS and the positions of groups as diverse as the Action Alliance for Children’s Behavioral Health⁵, The Philadelphia Alliance and Philadelphia Citizens for Children and Youth (PCCY) reflect the issues, concerns and urgency also found in cross-system plans such as Philadelphia’s Integrated Children’s Services Plan. These local documents resonate substantially with state and federal efforts such as the report of the Governor’s Commission on Families and Children, the recommendations of the Pennsylvania Search Conference on Children’s Behavioral Health and the final report of the President’s New Freedom Commission on Mental Health.

³Behavioral health services include both mental health and substance abuse services.

⁴ This Call To Action refers specifically to local and regional plans put forth by the Action Alliance for Children’s Behavioral Health, Philadelphia Citizens for Children and Youth, the Philadelphia Alliance (a group of behavioral health providers), the Philadelphia Department of Behavioral Health and Mental Retardation Services (2004 Strategic Plan), Philadelphia’s Annual Plan Update for Mental Health Services (FY 2006-2007), Philadelphia’s Integrated Children’s Services Plan, the recommendations of the Pennsylvania Search Committee on Children’s Behavioral Health, and the Pennsylvania Governor’s Commission on Children and Families.

⁵ The Action Alliance for Children’s Behavioral Health is a statewide, ad hoc group of parents and advocates with extensive experience with child-serving systems in the Commonwealth of Pennsylvania.

These documents contain many areas of consensus around the need for system reorganization, reorientation to the Pennsylvania Child and Adolescent Service System Program (CASSP) principles and other high priority areas to target. It has been recognized that service delivery models must emphasize prevention and early intervention and work toward the elimination of a system of care that is driven by crisis and acute services. In Philadelphia, the demand for crisis and acute services is enormous due to the lack of sufficient community-based services and a full continuum of easily accessible care for children and youth. In fact, this Call to Action evolved from concerns related to the seasonal overflow of children in Philadelphia’s designated Children’s Crisis Response Center and subsequent meetings between the Mental Health Association of Southeastern Pennsylvania (MHASP) and DBH/MRS. Despite planning between the Office of Mental Health and coordination with the School District of Philadelphia and other stakeholders, crisis services for children were overwhelmed during the spring as they have been for several years. Problem solving efforts included consideration that advocates, youth and families, and system partners work together to aggressively address the “upstream” problem of an inadequate continuum of care.

The lack of a full continuum of accessible care for children and youth invites crisis for families as behavioral health needs either are not met or are inadequately addressed. For example, long waits for outpatient appointments and a national shortage of behavioral health professionals to provide evidence-based psychosocial interventions make it likely that behavioral health problems will be exacerbated to the point of crisis. In addition, the fact that reimbursement rates decrease as level of intensity of service decreases results in a system in which provider systems are faced with a natural disincentive to move toward prevention and early intervention. Simply stated, we are failing our children and must recognize that unmet behavioral health needs of children and families is a serious public health crisis in our city.

We are confident that DBH/MRS will lead the way in system rejuvenation efforts by capitalizing on areas of consensus and responding to the groundswell calling for a new paradigm in the children’s service delivery system. Delivery of services must be a cross-system model that engages youth who may not be identified or do not access traditional services. Using a “systems

of care” approach, incorporating developmentally appropriate, evidenced-based services that truly integrate mental health and addiction treatment, DBH/MRS must move decisively to:

1. Create more flexible, community-based, family driven services in Philadelphia by integrating behavioral health services in the primary care settings of local neighborhood health centers;
2. Refocus community wraparound services and incorporate peer specialist support for children and adolescents;
3. Design and implement a continuum of respite care services for youth and families;
4. Deliver a continuum of mobile treatment and support services to children and families who are homeless and work with other systems towards eliminating the placement of youth in the shelter system;
5. Deliver flexible, cross-system, mobile supports and services to all transitioning youth receiving behavioral health services and provide youth with the skills needed to become productive, capable adults in their communities; and
6. Develop and implement a trauma informed system of care for children and families in the child-serving systems.⁶

BACKGROUND

In 2000, David Satcher, MD, the Surgeon General of the United States gave voice to the call for a national action agenda to make changes in children’s mental health services by announcing that “growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them.” Dr. Satcher placed mental health and mental health challenges back on the nation’s radar screen as a key public

⁶ Trauma informed care is defined as care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological, and social effects of trauma and violence on humans and is informed by knowledge of the prevalence of these experiences in persons who receives mental health services. (The National Association of State Mental Health Program Directors [NASMHPD], 2004).

health issue, particularly with respect to issues around suicide and self-harm for children and youth.

President George Bush, responding to consumers’ demands for making mental health and mental illness a national public health priority, established the President’s New Freedom Commission on Mental Health (New Freedom Commission) in April 2002. In May 2003, The New Freedom Commission recommended transforming how mental health care is delivered in America. Mental health care and service should be provided in ways that allow adults and children with serious mental illness to live, work, learn, and participate fully in their communities. The New Freedom Commission emphasized care must focus on increasing consumer’s ability to successfully cope with life’s challenges, on facilitating recovery, and on building resilience.

The New Freedom Commission’s Final Report specified six national goals which have shaped subsequent reform efforts. The goals are 1) Americans understand that mental health is essential to overall health; 2) mental health care is consumer and family driven; 3) disparities in mental health services are eliminated; 4) early mental health screening, assessment, and referral to services are common practice; 5) excellent mental health care is delivered and research is accelerated; and 6) use of technology to access mental health care and information. While mainly addressing issues in the adult mental health system, the report acknowledged efforts around prevention, research, services, and treatment for children and adolescents with behavioral health challenges must be strengthened nationally and at the local levels of government.

In 2003, Governor Edward G. Rendell signed an Executive Order establishing the Governor’s Cabinet on Children and Families (Governor’s Cabinet). The Governor’s Cabinet was created to identify barriers that prevent effective and efficient services, come up with solutions to problem areas impacting families, and streamline services for children and families. Headed by the Secretary of the Department of Public Welfare, a key goal of the Governor’s Cabinet is to build partnerships for stronger communities and promote service system change. The Cabinet serves as the Commonwealth’s front line responsible for working with stakeholders in developing local systems of care that deliver services through child-

centered, family focused, and culturally competent practices.

Here in Philadelphia, there have been discussions regarding the need to reform the child-serving systems around how children and their families can be reached and better served. Development of a full continuum of care requires engaging youth and families where they are (e.g. in their homes, schools and neighborhoods). Improvements in many areas of service system and treatment interventions are sought, including improved access to behavioral health services, attention to cultural differences, cost-effectiveness of services, efficacy of treatment interventions and integration of care across systems.

Cross system collaboration and identification of each child's developmental needs, their strengths/stresses and their functioning in every domain, are key to successful health outcomes. Specifically, mental health and substance abuse services and supports can no longer operate as separate entities. The developmental needs of children in all age groups including 0 to 5 must be considered. Creative use of proven non-traditional supports such as peer specialists is also recommended. Most important is involvement of youth and families in all aspects of service system design, evaluation and governance in achieving effective transformation.

We can transform the child-serving system and enhance the likelihood of positive outcomes for children and families in Philadelphia. The time has come to move beyond contemplation and planning toward action and implementation of bold ideas.

A CALL TO ACTION

Action Item 1:

Create flexible, community-based, family driven services in Philadelphia by integrating behavioral health services in the primary care settings of local neighborhood health centers.

“People with mental health disorders are routinely seen in primary care settings... While primary care providers appear positioned to play a fundamental role in addressing mental illnesses, there are persistent problems in the areas of identification, treatment and referral.”⁷

Why is it important to integrate behavioral health care in a primary care setting?

- Early identification, prevention and treatment can lead to better outcomes.
- To reduce the stigma of mental health issues.
- To reach underserved populations (e.g. homeless, poor, rural and urban populations).
- To create flexible, individualized, community-based, family focused services.
- To address the shortage of qualified mental health professionals and provide supports to primary care professionals around treating behavioral health.
- Evidence cited by the New Freedom Commission suggests quality screening and early intervention in readily accessible, low stigma settings, such as primary health care facilities are effective.

Many societal factors contribute to the health, safety, and well being of youth. Health promotion and prevention strategies should not be implemented in isolation. Therefore, a collaborative effort across multiple institutions is necessary as coordination and cooperation can strengthen efforts to address behavioral health issues. The integration of strategies can promote a comprehensive approach for addressing health related issues affecting children and youth.

We must assess and treat mental health with the same urgency that we treat physical health. Early identification of mental health challenges is vital for children and families. For example, “research has shown that parents of children, one to three years of age, are less likely to seek and receive professional help if their child has behavioral problems, in comparison to other developmental concerns.”⁸ As stated in the New Freedom Commission, we must work to eliminate the stigma surrounding mental illness and allow easier access to services for families. One way to do this is integrate behavioral health

⁷ New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*, U.S. Department of Health and Human Services, Pub. No. SMA-03-3832 (2003).

⁸ Data Trends (April, 2004). Prepared by the Research and Training Center for Family Support and Children's Mental Health, Portland State University.

services with primary care services in Philadelphia's neighborhood community health centers.

Several stakeholders have advocated making behavioral health services more available, community-based and family driven. For example, the Philadelphia Alliance recommended creating flexible services, establishing a culture of collaboration within and across systems, ensuring adequate access to developmentally appropriate interventions to children, and monitoring and maintaining adequate access to behavioral health services. While Philadelphia Citizen's for Children and Youth (PCCY) recognizes that, despite city and state efforts to improve the children's mental health system, there are not enough accessible community-based programs for children and their families.

By bringing behavioral health professionals into neighborhood health centers, more individuals in the community could be evaluated and treated. With an increased sensitivity to the need to reduce health disparities as well as an emphasis on early intervention, we must find ways to provide services in the community. Successful models exist for providing behavioral health service in a primary care setting. The Bridge Program offered at the Charles B. Wang Community Health Center in New York, New York, is an example where culturally appropriate behavioral health services and treatment are administered in a primary care setting.⁹ The New Freedom Commission and the Governor's Commission on Families and Children stress the importance of early detection, assessment and linkage with treatment in order to prevent mental health problems from compounding and leading to poor life outcomes across the lifespan.

**HIGHLIGHTED EXAMPLE:
MENTAL HEALTH INTERVENTION IN
PRIMARY CARE SETTINGS**

Partners in Care (PIC) is an integrated approach to improving depression care in diverse primary care practices. The model acknowledges that most patients with depression are seen in primary care settings and most are not treated effectively. PIC bridges the gap between patient needs and the organization and processes of primary care practices through key characteristics: collaboration between behavioral health specialists and primary care

⁹ Chen, M. Teddy, "Challenges and Opportunities: Mental Health Services in Asian Communities." Presentation at the Asian American Behavioral Health Symposium held in Philadelphia, Pennsylvania on May 19, 2005.

physicians, active case management and patient empowerment. PIC incorporates support for assessment, patient self-management and treatment choice.¹⁰

According to the Youth Partners-in-Care study at the UCLA Neuropsychiatric Institute, mental health intervention in primary care settings proves effective in improving depression and quality of life outcomes for depressed adolescents. The authors studied 418 youth with 344 completing a six-month follow-up. The population was chosen because they had a high level of unmet needs, which were addressed with a quality improvement intervention designed to improve access to evidence-based treatment for depression in primary care settings. Expert leader teams at each site adapted and implemented the quality improvement intervention. The study demonstrates that quality improvement interventions for adolescent depression are feasible in primary care settings. The study's findings show depression, quality of life and satisfaction with mental health treatment are improved by making treatment available in a primary care setting.¹¹

Wellness-including physical, mental, emotional, social, and spiritual health-should be promoted as ways to encourage healthy communities. DBH/MRS will continue to support community-based efforts which support children and families coping with mental health challenges.

REQUIRED ACTION

No later than January 2007, we call for DBH to train behavioral health staff on-site in a minimum of three neighborhood health centers with the capacity to provide evidence-based care for children and their families and to evaluate program and individual outcomes.

¹⁰ RAND Corporation (2005). Partners in Care Overview, www.rand.org. The Rand Corporation is a non-profit research organization that provides analysis for policy and decisions makers in both the public and private sectors.

¹¹ Asarnow, MD., Joan Rosenbaum, "Effectiveness of a Quality Improvement Intervention for Adolescent Depression in Primary Care." *Mental Health Weekly* (January 31, 2005).

Action Item 2: **Refocus Community Wraparound Services and Incorporate Peer Specialist Support for Children and Adolescents.**

“Consumers who work as providers help expand the range and availability of services and support that professional’s offer. Studies show that consumer-run services and consumer-providers can broaden access to peer support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with a psychiatric diagnosis.”¹²

Why should Wraparound services be refocused on the community and incorporate Peer Specialists?

- To create care and support truly individualized rather than menus of care.
- To administer a culturally competent, family driven process based on principles of resiliency and recovery.
- To bring flexible resources and natural supports to youth and their families in all environments that affect children- the home, school, neighborhood and community.
- To creatively mobilize all resources necessary to keep the child in the community.
- Peer Specialists can relate to the child and family’s experience in order to achieve greater access to the service system and boost the effectiveness of treatment by enhancing individualization of service delivery.
- Wraparound services implemented in the community and linked to a continuum of care have better outcomes for children and adolescents and are cost-effective.

It is recognized that, if services are to address the complex needs of children with emotional and behavioral disorders and their families, individualized, collaborative approaches are required. Wraparound should be the cornerstone of community-based services so that youth and families can learn to cope

with behavioral health issues and remain intact. Wraparound in Philadelphia has not adequately met the needs of youth and families. Problems with implementation have been addressed by restricting access to these services rather than meeting the challenge of providing effective interventions for the individualized needs of children and families in complex home and community settings. Recent innovations in Wraparound service delivery have focused primarily on school settings rather than the home environment. While school-based services are an important component in the continuum of care, they cannot be a substitute for community Wraparound.

There is consensus among stakeholders that Wraparound needs to be seen as an essential part of a continuum of care. Wraparound services must have two objectives: to therapeutically address the behavioral health needs of the child and to be flexible in order to meet the needs of the family and community. Wraparound should incorporate properties of engagement models proven to be effective for adults who are not ready to commit to traditional services. For example, placing Peer Specialists in existing organizations such as community recreation centers, after-school programs and libraries may enhance the capacity for youth facing behavioral health challenges to benefit from existing programs while increasing access to a range of behavioral health services. By having peer specialists and peer supporters in the community, youth whose needs typically strain the boundaries of these community groups may be able to participate without risking removal from the program.

WHAT IS A PEER SPECIALIST?

In the adult system a Certified Peer Specialist (CPS) is a person who has experienced a mental health and/or co-occurring disorder and has been trained to assist individuals to advance their recovery and strengthen resiliency. A CPS completes training in peer support, outreach, engagement, conflict management, crisis intervention and other areas.

“Peer Specialists” for the child-serving systems need further exploration and definition but will likely need to be adult mentors. Certification should be considered to ensure Peer Specialists meet established criteria. “Peer supporters” is a more general term and may include same age peers for youth to talk to and know they are not alone.

¹² New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*, U. S. Department of Health and Human Services, Pub. No. SMA-03-3832 (2003).

Building a Peer Specialist component into Wraparound services through existing youth and family-oriented community programs could assist youth struggling to identify with someone who has experienced what they are going through. The philosophy of peer support is grounded in a belief of empowerment through experience and personal knowledge. Empowerment is defined as “the ongoing capacity of individuals or groups to act on their own behalf to achieve a greater measure of control over their lives and destinies.”¹³ Peer Specialist programs are more targeted than generic peer support programs. These programs identify specific types of support and mentoring that assist in individual recovery and the Peer Specialist must demonstrate competency in order to be certified.¹⁴

in Chester County, Pennsylvania to provide peer support for siblings of children with special needs. In Montgomery County, Pennsylvania, the Trail Guides Program, a peer specialist program for youth between the ages of 18 and 22 with co-occurring issues, pairs young consumers with young adult mentors to assist with accessing need for services and working towards recovery.

DBH/MRS needs to use the valuable resource of peer support and create bold proposals for replication in the child serving system. We propose that certified Peer Specialists work with children in Wraparound, serving as role models and providing individualized support. Peer Specialists will also work with families who need support managing their own recovery and/or the special needs of other children.

REQUIRED ACTION

No later than January 2007, we call for DBH to have a certified Peer Specialist component integrated into all Wraparound services and place Peer Specialists in at least five existing community youth programs for children and families in Philadelphia.

HIGHLIGHTED EXAMPLE:

PEER SUPPORT FOR YOUTH AND FAMILIES

While Peer Specialist certification for youth and families is currently undeveloped, numerous states have implemented Peer Support Services (PSS) in their continuum of mental health services for adults. PSS are provided by individuals or family members who are mental health consumers and can help individuals and families navigate the system and cope with the stress of their needs. Georgia has provided recent outcome reports that not only emphasize the fiscal advantages of offering PSS, but the clinical success of recipients of this service in comparison to those who were only enrolled in day programs. Pennsylvania included PSS in the continuum of care for adults, recognizing this program is essential in helping adults meet their needs on the road to recovery. Applying this concept to the children’s behavioral health system could yield similar results.

We have witnessed the effectiveness of having peer parent advocates support families in accessing the skills and information needed to care for their children with behavioral health needs. The Parent Involved Network (PIN) hires and trains parents in Southeastern Pennsylvania, whose children are consumers of the behavioral health system, to work with other parents to provide support, hope and guidance. Two years ago, PIN implemented Sibshops

Action Item 3:

Design and Implement a Continuum of Respite Care Services.

“When the demands of care giving overwhelm caregivers, people with disabilities may be forced to leave their homes for a less desirable, more restrictive environment. Fortunately, respite services that provide temporary relief for caregivers can enable individuals with disabilities to remain in their homes and communities.”¹⁵

Why is respite care an important element in the continuum of care for children’s services?

- To reduce the need for crisis and acute care services.
- To reduce the risk of abuse and neglect.

¹³ Staples, L.H., Powerful ideas about empowerment. *Administration in Social Work*, Vol. 14 (2), p. 30 (1990).

¹⁴ The Action Alliance for Children’s Behavioral Health identified peer support as a missing component in children’s community-based services and proposed implementing Peer Families Advocacy Projects to “support families in accessing the skills and information needed to care for their children.” This project would serve as an alternate means to providing some of the functions that case workers have traditionally tried to address.

¹⁵ New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*, U.S. Department of Health and Human Services Pub. No. SMA-03-3832 (2003).

- To increase feelings of well-being and reduce feelings of depression and anxiety.
- To increase community and peer contacts for the individual with special needs.
- To increase family social activities, interactions and coping abilities.
- To strengthen the ability to provide in-home care and prevent out-of-home placement.
- Evidence suggests respite care services improve the quality of life for children and families and can reduce the need for crisis and acute services.

Families caring for someone with special needs often live with high levels of emotional and financial stress. The demands for care are ongoing and many families do not get the occasional, short-term periods of rest and relief that are important to the health and stability of primary caregivers. By providing these breaks, respite care can be a vital support to families. “Evidence shows that offering a full range of community-based alternatives is more effective than hospitalization and emergency room treatment.”¹⁶ In Philadelphia, we need to create alternatives to inpatient treatment along a continuum of care, which improves engagement in community-based treatment and reduces unnecessary out-of-home placement. Respite care services are an essential part of this continuum.

Philadelphia’s limited respite care services are short-term emergency placement out of the home. Respite care services should be provided in a variety of forms, depending on the needs of the child and family. Services must be provided in or outside the home and range from a few hours to a few weeks at a time. Both planned and emergency care should be available to youth and families. Care should be provided by agencies as well as less formal networks of families who receive appropriate supports for helping others.

The New Freedom Commission, DBH/MRS through its Strategic Planning Report (2004), the Action Alliance for Children’s Behavioral Health and PCCY have all called for a continuum of respite care services to provide support and maintain families. The Invisible Child Project Coalition, a diverse group of Philadelphia stakeholders convened over 2003-2004, identified emergency respite childcare for children

¹⁶ United States Public Health Services Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Services (1990).

between the ages of 6-13 years as a critical support for families affected by parental mental illness. Respite must include low end “drop in” type supports, at community centers and other facilities and organizations frequented by youth and families to provide a safe welcoming place with peer support.

**HIGHLIGHTED EXAMPLE:
NEW DIRECTIONS, VERMONT**

New Directions, a statewide initiative using a combination of state and federal dollars from the mental health, education, and social service systems, was developed to provide highly individualized services to the neediest youngsters in Vermont. Designed as a planned break for youth and families and with the overall goals of decreasing family stress and providing youth with age appropriate and enjoyable experiences in the community, respite care services are the priority in Vermont’s system of care plan.

Each community mental health agency has a respite coordinator who recruits and trains workers and matches workers to child and family. The matching process includes a review of child, worker and family interests, hobbies, activities, age, gender, scheduling needs and type of respite requested (e.g. in home, out of home, overnight care or a combination). Some programs offer small group respite options where two or three children, matched by age, interests and skills, participate in recreational activities together with one respite worker.¹⁷

The New Directions Initiative highlights the role of respite care services in a full continuum of care. Respite services in Vermont have worked because: 1) researchers found respite to be the most popular service component among parents caring for children with developmental or

¹⁷ Epstein, M. H., Kutash, K. and Duchnowski, A., Eds, *Outcomes for Children and Youth* (1998); and Santarcangelo, S., Bruns, Eric J. and Yoe, James T., *New Directions: Evaluating Vermont’s Statewide Model of Individualized Care*.

¹⁸ Cohen, S., *Supporting families through respite care. Rehabilitation Literature*, Vol. 43, pp. 7-11 (1982); Marcenko, M.O. & Smith, L.K., *Post adoption needs of families adopting children with developmental disabilities. Children and Youth Services Review*, Vol. 13, pp. 413-424 (1991).

¹⁹ Santarcangelo, S., *Consumer satisfaction: What children tell us about therapeutic case management and wraparound services*. Unpublished doctoral dissertation, University of Vermont, Burlington, Vermont (1994).

²⁰ Bruns, E.J. & Sturtevant, J., *Impact of respite care services on children experiencing emotional and behavioral problems and their families* (April 1996). This paper was presented at the Building on Family Strengths conference, Portland, Oregon.

behavioral problems;¹⁸ 2) Vermont's youth satisfaction with respite was correlated with the expression of fewer problem behaviors and with positive feeling about themselves;¹⁹ 3) families caring for children who utilized Vermont's system of respite care were found to utilize out-of-home placement less often than families placed on waiting lists for respite services, and they perceived the need for future out-of-home placement to be less than that of wait-list families;²⁰ and 4) respite was cost-effective compared to out-of-home placement.

DBH/MRS will creatively expand respite services to address the diverse needs of families as well as youth and create a network of providers who proactively assist families and youth by providing respite along a continuum – as a model for recovery, prevention and crisis intervention – ensuring children remain in their homes/communities and families will be strengthened.

REQUIRED ACTION

No later than January 2007, we call on DBH to have a minimum of three community-based respite care providers, one less formal network of families who provide respite, and establish drop-in respite for youth in partnership with three community youth groups.

Action Item 4:

Develop and implement Mobile Support Services, within a full continuum of care, for children and families who are homeless or in the shelter system.

“The lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in community life for people with serious mental illnesses. Today, millions of people with serious mental illnesses lack housing that meets their needs.”²¹

Why do we need to establish Mobile Support Services for homeless children and families?

- To work toward the goal of eliminating the placement of any child in the shelter system.
- To provide appropriate and reliable behavioral health services that will help this population make a successful transition to permanent housing.
- To help children and families access appropriate housing and other support services.
- To help children and families function as well as possible given their living situation.
- To ensure children can benefit from appropriate education while their living situation is unstable and after their living situation has improved.
- To address health disparities for children, particularly for our cohort of homeless children and youth.

The New Freedom Commission focused on the lack of affordable housing as a major barrier to accessing and maintaining mental health services. The Commission recognized affordable housing programs are extremely complex, highly competitive, and difficult to access and few mental health systems dedicate resources to ensure that people with mental illness have adequate housing with supports. Collaborations between public housing authorities and mental health systems are rare. The New Freedom Commission's findings reported “highly categorical Federal funding streams for mental health housing, substance abuse, and other health and social welfare programs greatly contribute to the fragmentation and failure to comprehensively address the multiple service needs of many people with serious mental illnesses.”²²

We must consider the behavioral health needs of children who are displaced with their caregivers. The lack of affordable housing and involvement in the shelter system results in inconsistent behavioral health treatment and services for children and adolescents. We need mobile support services within the systems of care for displaced and at-risk children. Living in the shelter system places children and families at risk of experiencing trauma and other forms of mental and emotional stress. Early intervention and prevention is necessary to reduce lasting harmful consequences and it is critical that homeless children are able to access and benefit from physical and behavioral health treatment and services.

²¹ New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*, U.S. Department of Health and Human Services Pub. No. SMA-03-3832 (2003).

²² New Freedom Commission Final Report, p.31.

A focus group of consumers and service providers, convened by the Governor's Commission on Children and Families, identified housing as a barrier to accessing coordinated and comprehensive services for youth. In a report entitled *Kids Come First*, the Governor's Commission found "several hundred thousand low-income families live in Philadelphia. Between 70 and 75% of these families face housing costs in excess of 30% of their income. Families, who pay less, often live in substandard housing."²³ The lack of affordable housing is a barrier to mental health treatment and a focus of national and local reform. In the June 25, 2005 edition of *The Philadelphia Inquirer*, a commentary article made the connection between affordable housing and the 10,000 children who spend part of their time in a homeless shelter each year. The editorial called for the creation of a trust fund to build or preserve housing for low- and median-income residents. Providing housing to children and their families must be a high priority for all the systems of care.

We envision a Mobile Support Service operated from neighborhood health centers, where statistics show there is a high population of homeless people, at the Office of Emergency Support Services, and in shelters (private and public) around the city. Mobile Support Services will travel, as needed, to various sites around the city providing a range of services to homeless children. Services will be a combination of case management, clinical treatment and non-traditional support services. This system of care would have to be highly flexible in its funding sources and treatment implementation in order to be successful sustained. If a child with a behavioral health diagnosis is homeless, the Mobile Support Service would be able to follow the child from shelter, to placement, to permanency. When a child moves among the shelter and transitional housing systems, it is difficult to provide consistent behavioral health services. Mobile Support Services would be able to transfer services across settings, provide consistency, and track outcomes.

Local mobile services, such as Prevention Point Philadelphia, have proven to be successful because of their ability to meet the client wherever the client is. Prevention Point Philadelphia provides culturally sensitive, non-judgmental prevention and care services for people who are active in their drug addiction and engage in sex work through three

programs in North Philadelphia. Services are provided free of charge and both the Syringe Exchange Program and HIV testing are anonymous.

**HIGHLIGHTED EXAMPLE:
THE PAPPAS SCHOOL, PHOENIX ARIZONA**

The Pappas Schools of Phoenix, Arizona serve over 1,100 students who are homeless by tailoring critical supports to allow these children to access and benefit from education. Shifting bus routes, (essential for children and families who move frequently); pantries where families can get groceries and clothing; and showers and a clinic are some of the ways the Pappas school recognizes and addresses students' distinct needs. More importantly, children have individual mentors and tutors and can sleep or get a meal as needed. The curriculum format acknowledges that homework is difficult to manage in the student's living situations and many students come to school each day without even the most basic supplies.

The Pappas schools are exempt from federal law that prohibits just such schools and guarantees homeless children the right to attend their original school. The Pappas model makes important strides toward recognizing that homeless children and their families have unique needs. These unique needs must be addressed for homeless children to attend school and make progress in their education. Homeless children and their families require customized Mobile Support Services to address the behavioral health needs and health disparities that are intrinsic to their living situations. Services must follow families through transitions until permanent community supports are in place.

DBH/MRS will deliver a continuum of mobile treatment and support services to homeless children and families and work with other systems toward eliminating placement of youth in the shelter system.

REQUIRED ACTION

No later than January 2007, we call on DBH to identify all youth in the shelter system and deliver appropriate mobile services addressing their individual needs. DBH will follow all of these families with appropriate services and outcome evaluations until permanent housing and community supports have been achieved and maintained for at least one year.

²³ Governor's Commission on Children and Families, *Kids Come First* (2005).

Action Item 5:
**Create an individualized
 Transition Team for every youth
 who is receiving behavioral
 health services between the ages
 of 16 and 21.**

“This transformation must ensure that mental health services and supports actively facilitate recovery, and build resilience to face life’s challenges. Too often, today’s system simply manages symptoms and accepts long-term disability.”²⁴

Why is it important to partner with youth to create Transition Teams?

- To develop supports and services meeting the unique needs of youth/young adults.
- To work toward the goal of optimal functioning across all life domains for transitioning youth and ensure they can grow fully and productively into adulthood.
- To reduce the risk of self harm through resiliency by offering hope, mentoring and peer supports.
- To successfully transition youth so they can live in least restrictive environments and are able to access the supports needed to function at their highest level in all areas of life.
- To reduce the number of homeless, incarcerated and unemployed young adults.
- Evidence suggests mentoring and peer supports for youth- important components of transition teams- reduces the severity of behavioral health problems and increases positive adult outcomes.

Adolescence and young adulthood is a critical period in human development. While there is opportunity to set the stage for success in adulthood, there is the risk of poor life outcomes. The fractured structure and poor integration across various child-serving systems, plus the absence of youth voice in determining services, can compound the problems facing youth with behavioral health needs. Homelessness, early

²⁴ New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*, U. S. Department of Health and Human Services Pub. No. SMA-03-3832 (2003).

exit from high school, unemployment or marginal employment, and violence are some of the consequences for youth who do not get culturally appropriate services and supports. Unfortunately, too many young people continue to have unmet needs as they transition into the adult system.

The National Institute of Mental Health found that half of all lifetime cases of mental illness begin by age 14. This research found despite effective treatments there are long delays, sometimes decades, between the onset of symptoms and when people seek and receive treatment.²⁵ The consequences are grave; as the New Freedom Commission found a majority of people who die by suicide had a mental illness. Far too often this mental illness was either undiagnosed or untreated.

Problems with treatment systems contribute to negative consequences. For example, failure to engage and treat youth with substance abuse challenges is a case study of inadequate response to a large but potentially manageable problem. The long-standing dichotomy between treatment for drug dependence and other mental conditions creates a barrier that prevents comprehensive treatment.²⁶ Research reveals by the end of high school, more than 55% of youth have tried an inhalant or illegal drug.²⁷ A recent survey of teens found even though 65% wanted to discuss substance use in their primary care setting, the topic was rarely initiated by their provider.²⁸ Thus many opportunities for identification, intervention or treatment of substance use are missed without cross-system collaboration and tailoring services to fit the needs of youth/young adults. Transition teams need to address these gaps for individualized youth while the systems of care develop better solutions.

Now is the time to actively engage youth in planning and determining their future if they are to live, work,

²⁵ U.S. Department of Health and Human Services. National Institute of Mental Health, press release (June 6, 2005).

²⁶ Jamieson, K. and Romer, D., “A Call to Action on Adolescent Mental Health,” *Treating and Preventing Adolescent Mental Health Disorders*, Oxford University Press (2005), p. 619.

²⁷ Commission on Adolescent Substance and Alcohol Abuse, “Substance Abuse Disorders,” *Treating and Preventing Adolescent Mental Health Disorders*, Oxford University Press (2005), p. 343.

²⁸ Meyer, K. and McLellan, A. Thomas, “The American Treatment System for Adolescent Substance Abuse,” *Treating and Preventing Adolescent Mental Health Disorders*, Oxford University Press, (2005), p. 563.

learn and fully participate in their communities. The ideal age range for transition services and supports is between the ages of 14-25. Evidence suggests that for youth with behavioral health issues, the key to successful transition is to start as early as possible and to have skilled behavioral health specialists who guide youth toward a future focus. Failure to address their unique strengths, needs and opportunities to develop, sentences many youth to marginal opportunities for successful aging and can lead to negative outcomes later on in life. Innovative programs using system integration, youth voice and creative approaches, hold hope for transforming the type and value of services and supports for youth.

In the past 30 years there have been intense efforts to develop and implement prevention and positive youth development programs. Interest in positive youth development has grown in the United States as a result of studies showing that the same individual, family, school, and community factors often predict positive and negative outcomes for youth. Positive Youth Development (PYD) is a prevention model aimed at fostering resilience and promoting social, emotional, cognitive, behavioral and moral competencies in youth. By recognizing positive behavior and opportunities for pro-social involvement, various types of PYD programs help to strengthen youth. The model acknowledges youth cannot be insulated from stress, real life obstacles and difficult decisions, but by building competencies in a supportive environment they will be more likely to make healthy choices that support their goals.²⁹

Philadelphia was a site of a PYD program aimed to help inner city at-risk youth complete high school. The Quantum Opportunity Program (QOP) targeted youth with low grades entering high schools with high dropout rates. QOP's goal was to increase the rates of high school graduation and enrollment in postsecondary education or training. Fifty youth were enrolled and followed over a five year period. The Philadelphia pilot had a significant beneficial impact

²⁹ Positive Youth Development programs do not necessarily target youth identified as having behavioral health concerns and therefore can serve youth who may not access traditional services and supports. Social Developmental Research Group of University of Washington, *Positive Youth Development in the United States* a report for National Institute of Child health and Development of the U.S. Department Health and Human Services, Executive Summary p. 2 (1999).

on attending postsecondary education or training, attending high school or a GED class, or working. The program was less successful in reducing risky behaviors such as crime and binge drinking. The success in Philadelphia was credited to higher spending per enrollee (\$49,000 per enrollee over 5 years) and highly motivated mentors/case managers working with youth.

**HIGHLIGHTED EXAMPLE:
THE TRAIL GUIDES PROGRAM,
MONTGOMERY COUNTY, PENNSYLVANIA**

The Trail Guides Program (Trail Guides) is a mobile, one-on-one mentoring program designed to guide and support young adults between the ages of 18 and 22 who have emotional and behavioral health disorders as they transition from the children's behavioral health system into the adult serving system. Experienced guides- adult consumers who serve as mentors and who have encountered the emotional trauma, social stigma and career discrimination associated with mental illness - help program participants develop a goal plan to fulfill their social, educational, occupational and personal aspirations.

Trail Guides is based on the time-tested practice of an experienced adult providing support and advice to a young person in need of guidance. Trail Guides can help young people choose paths that lead to independent and productive lives in the community rather than to criminal behavior, violence, drug and alcohol abuse, and irresponsible sexual activity. Trail Guides is a program to help young people avoid more serious emotional and behavioral problems that require costly emergency care, hospitalization, and long-term out-of-home placement.

Trail Guides is rooted in the principle that adult mental health consumers will make the best mentors for young adults with mental illness. Consumer-mentors will know the bends in the road, the slippery slopes, and the danger signs along the way. Their real life experience and struggles with mental illness can serve as gentle reminders that recovery is possible. The Trail Guides program currently operates in Montgomery County, Pennsylvania and has an enrollment of up to 25 young adults.

Transformation of the children's behavioral health system must include a model for youth transitioning into the adult system and encompass goals that address all the life domains. Such a model must include a component of youth mentoring and peer support. Youth transitioning into young adulthood need to nurture their strengths- whether a youth is struggling to attain an education, needs vocational training to realize their dream or has developmental

challenges to their independence in the community. For youth, connections to peers, individuals, and organizations are important to developing skills and a vision of what their life can be.³⁰

We must give youth the skills they need to develop resiliency and achieve recovery by preparing them for successful adult lives. Therefore, DBH/MRS will deliver flexible, cross-system, mobile supports and services to all transitioning youth receiving behavioral health services and assist them in becoming productive, capable adults in their communities.

REQUIRED ACTION

No later than January 2007, we call on DBH to identify all youth in the behavioral health system between the ages of 16 and 21, and deliver appropriate support across all life domains through individualized Transition Teams. The teams will provide youth planning, peer support and mentoring, and school re-entry support. DBH will follow these youth for a full year after successful transition to the least restrictive environment and will ensure their ability to obtain needed supports and services.

Action Item 6:

Develop and implement trauma-informed services for children and families in the child-serving system.

“The mental health field lacks sufficient information about dealing with trauma and its effects on different populations.”³¹

³⁰ Research and Training Center on Family Support and Children’s Mental Health. *Resilience and Recovery*, Focal Point (summer 2005), Portland, Oregon.

³¹ New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. U.S. Department of Health and Human Services, Pub. No. SMA-03-3832 (2003).

Why do we need evidence-based trauma-informed services for children and families?

- To create systemic understanding and awareness of the complex biopsychosocial and developmental impact of trauma and abuse.
- To treat youth who have experienced trauma, increase resiliency and coping abilities, and decrease the likelihood for re-enactment behavior.
- To ensure appropriate early intervention and prevention when addressing trauma throughout the continuum of behavioral health services.
- To address the needs of children exposed to violence in their homes and/or communities.
- To reduce the need for crisis and acute care services.
- Evidence suggests that prevention and intervention are not only possible but effective in the earliest years of life. Interventions and treatment for traumatized youth can take place in many settings.³²

Trauma is a serious, widespread problem that is a threat to our public health. The New Freedom Commission identified trauma as one of four key areas for the nation to address. “Twenty-five percent of children surveyed in one major study had experienced a traumatic event by the age of 16. An estimated 4 million youth have experienced a serious physical assault, and 9 million have witnessed serious violence. Estimates of the number of children abused, neglected, or exposed to domestic violence exceed 3 million cases annually.”³³ In Philadelphia, too many children are the victims of abuse and neglect, witness domestic violence, and are homeless or at-risk of being homeless.

According to the National Child Traumatic Stress Network (NCTSN),³⁴ trauma can interfere with a child’s ability to think and learn and disrupt the path of healthy physical, emotional, and intellectual development. Long-term consequences of trauma may include substance abuse, poor school

³² Osofsky, J., Treating young children exposed to violence. *The Brown University Child and Adolescent Behavior Letter*, (February, 2005).

³³ Based on research cited in *Children and Trauma in America: A Progress Report of the National Child Traumatic Stress Network* (2004). www.NCTSN.net.

³⁴ The National Child Traumatic Stress Network is coordinated by the National Center for Child Traumatic Stress, located at the University of California at Los Angeles and Duke University, North Carolina.

performance, mental health disorders, and physical health conditions. Given the number of children exposed to trauma, it is important we increase efforts to address the harmful consequences of trauma and promote resiliency. Research now demonstrates that all people have the traits to be resilient, but it is how these traits get nurtured that is key.³⁵

In order to address the special needs of these children in ways that will promote resiliency and recovery, trauma-informed services must be infused throughout the child-serving systems. DBH/MRS and providers have to respond to the most at-risk youth in a manner that will treat their symptoms and better understand their changing needs for recovery. Even if trauma-specific symptoms fade, traumatized youth can become progressively more reactive, vulnerable, and display other psychiatric symptoms as the trauma burden grows. This can lead to a range of problems and limitations in quality of life. In our complex urban reality, it is crucial that we provide trauma-informed training to those who encounter these children. From a public health standpoint, education and outreach with the Philadelphia Police Department, the court system, schools including the School District of Philadelphia and the Archdiocese of Philadelphia, counselors, therapists, DHS social workers, health care professionals, faith-based communities and juvenile law enforcement is necessary in order to effectively identify and treat trauma victims and ensure early intervention opportunities.

**HIGHLIGHTED EXAMPLE:
THE SANCTUARY MODEL**

The Andrus Children's Center in Yonkers, NY provides a broad spectrum of preventive and restorative services for families and their children from birth through adolescence. In recent years, the Center has adopted a trauma-informed model for treatment to address the needs of children who have been subjected to abuse, neglect, violence, and other forms of trauma.

The Sanctuary Model, developed by Sandra Bloom, MD is a trauma-informed method for creating or changing an organizational culture. It is a full-system approach focused on helping injured children recover from the damaging effects of interpersonal trauma. Implementation of the

Sanctuary Model requires extensive leadership involvement in the process of change and staff and client involvement at every level of the process. Originally developed in short-term, acute inpatient psychiatric setting for adults who were traumatized as children, the Sanctuary Model has been adapted by residential treatment settings for children, public schools, domestic violence shelters, outpatient settings, substance abuse programs and parenting support programs.

The Sanctuary Model has been used in other settings as a method of organizational change. It has proven to be a successful model in addressing youth experiencing trauma.

DBH/MRS should seek to partner with national experts to design a trauma-informed system of care and implement trauma-informed services throughout the continuum of care for children and adolescents.

REQUIRED ACTION

No later than January 2007, we call on DBH to hire and train trauma-informed Peer Specialists, Mobile Support Services, and staff in the three neighborhood health centers providing behavioral health services. DBH will assess the impact of these interventions in order to plan for full implementation of trauma-informed services in the children's system based on experience in Philadelphia as well as research from other communities.

CONCLUSION

This is a call to action for the City of Philadelphia to move away from a tradition of planning and discussion toward a new tradition of innovation, implementation and immediate action. This paper contains short-term recommendations a part of an overall transformation of the behavioral health child serving system. This paper does not aim to provide a comprehensive inventory of the need for services impacting children and adolescents, but instead targets key areas of concern where there is consensus by many diverse stakeholders. It is essential to implement all of these required actions in order to galvanize system transformation. Pilot projects in a few areas are not sufficient to meet the need for reorienting the system to prevention and early intervention.

³⁵ Based on research cited in Children and Trauma in America: A Progress Report of the National Child Traumatic Stress Network (2004). www.NCTSNet.org.

The required action steps listed in this paper represent the beginning of a blueprint for radical change in improving behavioral health services for children and adolescents. The six highlighted recommendations will require thoughtful implementation and cooperation between and among various City departments. Should DBH/MRS and other departments agree to fully implement these recommendations, evaluation data should lead to informed decisions on expansion or development of additional services for children and adolescents.

We can no longer do business as usual and fail to meet the challenging behavioral health care needs of our children. Services to youth and their families must embrace resiliency and recovery and we must improve our efforts around prevention and awareness. We must fully incorporate mental health and substance abuse supports and services to serve youth.

The time to act is now. The question remains, do we have the commitment to take critical steps in the next phase of system development here in Philadelphia? We believe the answer in a resounding yes!