Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated.
For a listing of all the Erich Lindemann Memorial Lectures, please visit
www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE THIRTY THIRD ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Meeting the Mental Health Needs of Children and Families: Policy and Current Strategies

Protecting the wellbeing of children was one of the earliest approaches to preventive mental health intervention. Now children and their families are most vulnerable in an era of decreased public service and economic resources. We present the current status of child mental health services, policy trends at a time of overhaul of the nation's mental health system, and the Rosie D. case stimulating a community mental health approach to improving mental health services for children in Massachusetts. Can this be a lesson for a national mental health program?

Speakers

Rep. Ruth B. Balser, PhD, State Representative, Commonwealth of Massachusetts, Vice Chair, Joint Committee on Public Health. Member, Joint Committee on Mental Health and Substance Abuse

Emily Sherwood, Director, Children's Behavioral Health Interagency Initiatives (CBHI), Commonwealth of Massachusetts Executive Office of Health and Human Services

Peggy Kaufman, MEd, MSW, Director of the Center for Early Relationship Support, and faculty member of Infant Parent Training Institute, Jewish Family and Children's Service of Greater Boston; clinical practice, consultation, and supervision

Marylou Sudders, MSW, ACSW, President and CEO, Massachusetts Society for the Prevention of Cruelty to Children (MSPCC); former Commissioner, Massachusetts Department of Mental Health

Moderator

David G. Satin, MD, DLFAPA, Assistant Clinical Professor of Psychiatry, Harvard Medical School, Chairman, Erich Lindemann Memorial Lecture Committee

June 11, 2010, 2:30 – 5:00 pm

Massachusetts School of Professional Psychology
221 Rivermoor Street, Boston, MA 02132

Introduction by David G. Satin, MD

Now for the topic of Meeting the Mental Health Needs of Children and Families: Policy and Current Strategies. The format of the lecture will be a presentation by the speakers. In order of presentation they are; Dr. Ruth Balser, speaking about the development of policy addressing children's mental health; Emily Sherwood, speaking about the coordination of child mental health policy over many agencies and programs; Peggy Kaufman, speaking about the implementation of mental health services for children in a specific agency; and Marylou Sutters, speaking from the perspective of community agencies and residents about the mental health needs of children and the services that are and *should* be available to them. After the presentations, there will be discussion among the speakers, and we hope that you will participate as people with experience and with interest in this field.

John F. Kennedy's famous special message to the Congress on mental illness and mental retardation on February 5th, 1963 addressed the issue of children's mental health. He said, "The anguish suffered both by those afflicted and by their families transcends financial statistics," particularly in view of the fact that both mental illness and mental retardation strike so often in childhood and lead to a lifetime of disablement for the patient and a lifetime of hardship for his family. He also addressed the social and community aspects of child mental health. He said that socioeconomic and medical evidence are indicative of a major causative role for adverse social, economic and cultural factors. The families who are deprived of the basic necessities of life, opportunity, and motivation have a higher proportion of the nation's retarded children. The only feasible program with a hope for success must not only aim at the specific causes and the control of mental retardation, but seek solutions to the broader problems of our society with which mental retardation is so intimately related.

Child mental health care was one of the earliest examples of mental health preventive intervention, which is a key element of community mental health. The early focus on physical health, housing, nutrition, schooling, parent education and what was called habit training, especially for poor and immigrant populations, gradually shifted to psychoanalytically-oriented treatment of and research about individual sick children and their families. More recently, through our government society has withdrawn from providing treatment or treatment facilities for children's mental health in favor of private and voluntary sources. Even more recently, there has been a backlash of demand that children's mental health needs be met, though these conflicts with reluctance about public responsibility. Our distinguished speakers can help us to understand how community concern for child mental health meets public policy and care giving.

Ruth Balser, PhD

State Represetnative, Commonwealth of Massachusetts; Vice Chair, Joint Committee on Public Health; Member, Joint Committee on Mental Health and Substance Abuse

Introduction by David G. Satin, MD

Our first speaker is Dr. Ruth Balsar, who is serving her sixth term as State Representative for the Twelfth Middlesex District. Human Services, health care, and economic and social justice are among her priorities. She was appointed the First House Chair of the Joint Legislative Committee on Mental Health and Substance Abuse. She was active in regard to the Massachusetts Children's Psychiatry Access Project and Children's Mental Health Bill. She earned her Ph.D degree in Psychology from New York University and has practiced in community mental health, managed care, and private practice. In 2008, she was awarded an Honorary Doctor of Humane Letters degree by the Massachusetts School of Professional Psychology to add to many other awards and citations. She will help us to understand how community need becomes public policy.

Rep. Ruth B. Balser, PhD

Thank you very much. It's a pleasure to be here. It's always a pleasure to be at MSPP, where I have so many friends, colleagues, and partners. I appreciate your leadership, Dr. Satin, in continuing the tradition of community mental health, which is so important and actually where the beginning of my career started. So we're here today to talk about meeting the mental health needs of children and families. My talk is going to be about politics so that may not come as a huge surprise since you know I'm a politician, although I'm also a psychologist. I like to brag about the fact that I'm the first psychologist to ever serve in the Massachusetts Legislature, so [applause] thank you!

But you know I'm struck…when I went to graduate school and got my doctorate I'm quite sure that none of the classes I had addressed politics or advocacy. Not that we didn't talk about politics on the side, you know, amongst friends. But as a matter of study, it was not part of it. I was certainly taught psychodiagnostic assessment and psychotherapy, and even a little about how to do some research. But, I was really not taught that meeting the mental health needs of people would have anything to do with politics or advocacy. What I'm going to talk about today is that I think a lot of us have come to realize that to really meet the needs of people, one actually *does* have to get involved with politics and advocacy.

So what I'm going to do today is just tell a story about the politics that have happened in the last decade around the issue of children's mental health. I'm delighted to share the panel with two people who played a huge role in that story, and maybe in their remarks they'll get to tell it their way. As people in mental health, we all know that each of us tells history in our own way, but Emily Sherwood was the policy advisor to a wonderful colleague of mine who had chaired the Committee on Health Care and Finance, and Mary Lou Sutters in addition to having served as the Commissioner of the Department of Mental health has been a leader in the children's mental health campaign. But of course as I like to tell the two of them, because I'm the legislator who got to file the Bill, I'll take all the credit. [laughter]

Actually, that's not true. I want to talk about…and if someone is looking for a dissertation topic, they really should do a study on Chapter 321 and how the Children's Mental Health Act got passed. It's a wonderful story about the combined efforts of legislators, the governor, the courts, the media, mental health professionals, mental health consumers, advocates, and policy advisors. It's really a wonderful story, so I'm going to try to tell my version of that story in these next minutes that I have. I hope it's useful in terms of understanding one of the ways in which we meet the mental health needs of people is to pass good legislation to fix problems.

So I'm going to start the story a decade ago because I want to even throw the National Government into the mix. The United States Surgeon General issued a report in 2000, the report asserted that children's mental health is an essential part of overall health for children. Here in Massachusetts, there are a lot of people who feel that that message has not been implemented, that there are serious problems with our mental health system, and it's not just mental health professionals. In 2001, the Massachusetts Chapter of the Academy of Pediatricians established a Children's Mental Health Task Force. The pediatricians got into it because they were seeing a lot of kiddos in their office who they knew needed something beyond what they, as primary care physicians, could provide. But they were having trouble getting it to them and they were feeling that families were coming to them for needs that really they should be going to mental health professionals. But no one could find a child psychiatrist, there were all kinds of problems, so the pediatricians became major players in this story.

In 2002, the Boston Bar Association issued a report. I'm pretty sure Marylou Sutter's name is on that report. She shows up on all the reports. It's interesting that the Boston Bar Association got into the act, and they brough together a group of professionals, advocates, and people who were concerned about the problems facing children in accessing mental health services. Now they were responding in part to things they were seeing, as I mentioned with pediatricians in their office, but also there began to be media coverage. The media had something to do with this story too, because the media started reporting on the problems children faced in accessing mental health services.

And we began to hear a phrase called "stuck kids," which actually became common parlance, which is interesting in itself. If you are not familiar with the term struck kids, there began to be a phenomenon of young people- teenagers and children- who were hospitalized in psychiatric units who, once they became stable and no longer needed to be in the hospital, weren't leaving the hospital. And they weren't leaving the hospital because there was no place for them to go. These were youngsters who it was deemed that they really shouldn't or couldn't go back to their own families, and there was really no continuum of care, step down services, group homes, or rehabilitation programs. So these kiddos got stuck on the units, which of course created a problem for new children in crisis who needed those beds they couldn't get in.

So "stuck kids" became a topic in the media, and these reports started coming out like the Boston Bar Association, and we started to hear these themes about the problems children face accessing services, the need for early detection, and lack of coordination of services. Children who were showing up at the Department of Mental Health, also the Department of Social Services, maybe Juvenile Justice, no one was coordinating their mental health needs.

So the politicians get into it at this point because that's what we do, we respond to public needs. A good friend and colleague of mine, Representative Ellen Story, who represents Amherst, filed a little amendment to the state budget…It's interesting, a lot of things happen not through legislation, but through budget amendments. Anyway, she filed an amendment to the state budget to say that she wanted to set up a state commission to start collecting data and studying the problem of stuck kids. And that amendment survived, and it is not easy for budget amendments to survive, but that one did. The governor signed it and we had the Commonwealth of Massachusetts as a statutory matter requiring the creation of a commission that was going to look at children's mental health.

Somewhere in here, my good friend and fellow representative from Newton, Representative Kay Khan, established a mental health caucus. I like to share with people, I know Kay's not here, but we refer to each other as "partners in crime." Kay is a psychiatric nurse and I'm a clinical psychologist, and we both represent Newton. And we like to quote the statistic that Newton has the greatest density of mental health professionals of any community in the country. So it is perhaps not an accident that they sent two mental health professionals to Beacon Hill. Kay started a mental health caucus, they held a forum on children's mental health. You were probably there, Marylou, I'm sure. I remember the pediatricians were there, and actually that was when my involvement came. I went to that forum and became more educated about what was going on with this children's mental health crisis.

After the legislature became involved, the professionals became involved. Of course, what happened next was that the courts get involved. There was a lawsuit called Rosie D. v. Romney, and the Massachusetts courts ruled that our Commonwealth violated Federal Law by failing to provide home-based treatment to 15,000 children in the Commonwealth. This was pretty staggering actually, to have the courts call us out like this, us meaning the Commonwealth, that we were really not meeting the needs of children in Massachusetts.

Then Marylou really does get into this story, and I'll let her tell it her own way. But in November 2006 her organization, The Massachusetts Society for The Prevention of Cruelty to Children (MSPCC), partners with the Children's Hospital of Psychiatry, and a long list of medical and mental health organizations issued a report sounding the themes again about this broken mental health system for children, the problems with insufficient insurance coverage, and insufficient public services for children. So then they brought in the heavy guns. They brought in Healthcare For All, a great champion for the Rights of the People of Massachusetts. So I'm going to turn the channel to my part of the story, which is that I ran for office in 1998. I mentioned already that when I was elected to the legislature, I was the first psychologist. But I like to tell the story about when I first ran and I began to call the people of Newton to ask for their support. That's what you do when you decide to run, you get on the phone to everyone you know.

She's not in the room but I'm sure many of you know Elena Eisman, who is the Executive Director of Massachusetts Psychological Association- she's also a constituent. I like to tell the story that of all the people I called that first year when I was running for office, she was the most enthusiastic. She literally squealed on the phone and said, "Oh my gosh, we're going to have a psychologist in the legislature!" Now I didn't actually know why she was so excited about that, and the reason is that I didn't really feel that I was running as a psychologist. I have this other life that I really love and am passionate about- politics. I hadn't really thought of the two as being connected. But I like to tell the story because Elena sort of knew that once I got into the legislature, I would find my way into mental health public policy. And that is exactly what happened, I found myself advocating for mental health services all during the first years that I served in the legislature.

During the first six years, the House was under the leadership of Speaker Finneran, and Speaker Finneran's politics were very different from those of my constituents. He was a conservative, and my constituents are quite liberal, so there were many battles during those years. I was part of a group of backbenchers known as Finneran Dissidents, and we were the liberals. I mention it because as word got out that Speaker Finneran was going to be resigning and a new speaker, there was a speaker fight going on. Anyway, I placed my bet on Sal DiMasi, because he was the liberal in the race. And an amazing thing happened- he won. He got elected and I was so excited that we had a speaker who supported marriage equality, civil rights, and civil liberties, but he went further than I ever guessed in his opening speech when he was sworn in as the House Speaker. He said that there were a couple of public policy issues that had been ignored too long, and under his leadership that was going to change, and on the top of the list was mental health. He said in that speech that mental health was going to be a top priority under his leadership.

I really flipped. I thought "Oh my god, I really did back the right horse!" This is someone who really cares about mental health. What happened next was he and the Senate President Travaglini reorganized the legislative committee structure for the first time in over 20 years, and they formed new committees. One of the new committees that they formed was the Joint Committee on Mental Health and Substance Abuse. So this was really historic, it's unique in our nation for a state legislature to have such a committee. But it represented a real commitment on the part of the Massachusetts Legislature to the issues that we care so much about. Well, I got very excited and you could say I asked, others might say I begged, to be appointed the first House Chair. So Speaker DiMasi did that, and there were a lot of interesting comments made by people like, "Oh my god, it's a psychologist who's going to chair the Committee on Mental Health and Substance Abuse!"

Well there's a really wonderful thing about when you get to be in leadership and you get to be a chair of a committee, which I've learned because I've served now under three Speakers, two back benches, and once in leadership. And what happens when you're in leadership, the speaker comes to you and says, "What are your priorities?" So, it's great! I had two priorities as Chair of that committee- one was to pass mental health parity legislation, which is to expand what we had done in 2000 and make it so that almost all diagnoses would be fully covered, and the other was to pass a landmark children's mental health legislation.

So let me circle back to the advocates part of it. While I was running around doing the inside game of working with a Speaker who wanted to do something important in mental health, the outside advocates were meeting for years, actually doing the hard work of drafting legislation. And this coalition that was developed with psychiatrists, mental health professionals, the families of mentally ill children, and health care advocates, they were out there meeting and actually drafting legislation. That's how bills get written- it turns out a lot of times by people in the community. What they did was they would come to me and my colleague, Senator Steven Tolman, and they ask if we would be willing to sponsor this bill. So of course, we were delighted to do that. At this point, the Senate President was used to hearing from Steven Tolman about drug addiction and mental health, and at this point Speaker De Macy was used to hearing from me about mental health parity and children's mental health, and so the time was right.

I want to tell you uh a little bit more about how we got this important legislation passed and a little bit about the Bill. The advocates did something really smart, which is to make the problems real. So not only did they give you statistics about how many children were waiting for services, and not only did they do really intelligent analyses about how the system had broken down, but they brought at least two particular people. One was the mother of a mentally ill child to meet with the speaker, and this woman was a professional, extremely well educated and articulate and had resources. And she talked about how hard it was to get her child services, even with all the advantages she had, and I know the Speaker never forgot that conversation. Then in the midst of this a young woman came and testified before my Committee on a children's mental health bill about an adolescent who had suffered from mental illness and ended up committing suicide. Her mom became a champion for passing legislation, and she came to meet with the Senate President. I know that hearing the stories about the difficulties of children getting their needs met really made a real difference to the leadership and the members of the legislature.

So 2008 was a good year- we passed. I was surprised actually to hear Dr. Covino start by saying how terrible things were, because I actually thought we had solved the problem when we passed Chapter 321 of the Acts of 2008. But it really was a tremendous victory, we passed legislation which addresses so many aspects of the problems that children and family face. It addressed the issue of getting consultation into the schools and preschools so that we could have early detection of psychological problems. It addressed the issue of getting behavioral health screening into the pediatricians' offices. It addressed a lot of the Rosie D. stuff that came out of the Bill, because Emily Sherwood got the wonderful job. I should mention- remember that Bill was called Rosie D. v. Romney? Well, the Patrick Administration was very proactive when they came in with wanting to implement a plan to address the court decision, and by the time we got the Bill passed, they were already up and running with many elements that had been in the Bill. I'll let Mary Lou tell you more about the Bill.

So we have a problem now, which is one of the toughest pieces of politics I've learned, which is fighting with the insurance industry. They are really formidable. You may experience that when you are on the phone with them for your individual clients. We have experienced it when we try to get legislation passed. We had a big victory in 2008 when we passed my Mental Health Parity Legislation, although it did get watered down at the end because of the lobbying of the insurance industry. And we did loose a piece of our Bill because of the insurance industry, and that piece was the one that would have required the health plans to pay for the collaboration that you do with pediatricians, teachers, and day school providers. So we came back this year, the advocates once again asked me and my partner, Steve Tolman, to file a bill. This year's story is not as good, although its not over yet. But things change in politics and positions have moved around. There are different people in key places, and that bill was defeated by the Healthcare Finance Committee, although we're still working on trying to get it to show up somewhere else.

But I guess that leads me to my punch line that I always tell everyone, which is that politics is very much like house work- it's never done. You clean one mess up and the dust comes back. And so, I am very proud of what we've accomplished, and by we I mean the legislators, the governor who signed the Bill, Marylou Sutters, Boston Children's Hospital, the members of PAL, and all the many people that got that legislation passed. But my message to you is to be really involved in advocacy because it makes a difference. There were hundreds of people who showed up at rallies and who visited their reps and senators. I left that out because I told the leadership part of the story, but the members were persuaded by their constituents to do something about children's mental health. So, I look forward to your questions, the conversation with my colleagues, and that's the political story. Thank you. [applause]

David Satin:

Thank you. The thoughts that I had were- first, you talked about how the policy is made. Implementation is a big piece of what actually happens. Secondly, I'm reminiscing that Erich Lindemann's first community mental health center in the United States was one that Erich Lindemann developed in Wellesley- the Wellesley Human Relations Service- and it came about because the citizens of Wellesley asked for help because their children were not able to find mental health services at other agencies. They wanted to find some way of developing more local mental health services for children. And third is, I don't think you and Ms. Sutters ought to feel bad about talking about the same issue. To me, you are two ends of the same community values and action. You are the whole, because you are both representing the community, from the community advocacy group and from the government, which is supposed to be representing the community.

Emily Sherwood

Director, Children's Behavioral Health Interagency Initiatives (CBHI), Commonwealth of Massachusetts Excutive Office of Health and Human Services

Introduction by David G. Satin, MD

Emily Sherwood has over twenty years of experience in public sector health care and human services policy and program development. Currently, she is Director of the Children's Behavioral Health Interagency Initiatives, overseeing implementation of the court judgment in the case of Rosie D. v. Romney, requiring the Commonwealth to substantially expand community-based mental health treatment services for youth enrolled in the Medicaid program. She has managed the interagency process for the state's first pilot system of care for children with serious behavioral health needs and their families, resulting in the mental health service program for youth, delivering clinically effective, culturally competent and integrated medical behavioral health and social support services. She will help us to understand the road to policy implementation.

Emily Sherwood

Well, thank you for having us all here today. It's always nice for me to get out of my usual routine and to prepare for an event like this. It gives me a chance to reflect on the work that we all do together. It's actually a treat for those of us to see each other- those of us who we all work together but we don't get to see each other very much. I wanted to say for those of you who are interested in politics and in the role of women in politics, Ruth Balser would be a wonderful person for you to talk to. I worked as a staff person in the legislature for a 9-year period of time and then a 2-year period of time. It's actually very challenging for women to find a successful leadership style in the legislature. It's a very culturally male institution and Representive Balser is one of the most effective women politicians I've ever seen in the legislature, and is really impressive. So if you're interested in that, certainly talk to her more about it.

So what I'm going to talk about, let me just ask, before you heard about Rosie D. today, how many people had heard of the Rosie D. case before? O.K. great! So I'm going to try and do two things at once. One is to give you an overview of what it is that we have implemented and kind of give you enough information and some resources where you can learn more. But I really want to use it as an illustration of policy development and particularly the role of litigation in policy development and some reflections on that.

So let's start at the beginning. This is a class action lawsuit brought in 2001. Lawsuits take a long time, and it didn't go to trial until 2004, I think, and there wasn't a decision until 2006. Then there were months and months and months of negotiation of what the actual remedy was going to be, and then they had to implement the remedy. Some of the kids who were the named plaintiffs in the case aged out of the services before the case was resolved, so this is one of the things that happens in litigation.

It is a Medicaid lawsuit, and this is where you have probably heard this word before. There are certain laws that are Federal entitlements and that means that it's established in statute that if you meet the eligibility criteria for that service, whether it is a federal or state, the entitlements are federal. The state has to deliver the service, you can't just say that you don't have enough money. So entitlements are very important and you can use an entitlement statute to sue and say that the government is not doing enough to meet it's obligations under the statute.

So this is what's called an EPSDT lawsuit, and EPSDT was something that was added to the Medicaid statute, the federal statute in 1967. The idea behind it was to ensure that Medicaid programs around the country paid for preventative care for kids. So people were thinking about pediatric care and making sure that state Medicaid programs were paying for well child visits, and were doing screening of a whole lot of different medical and behavioral health conditions in that visit. Then the Medicaid program had to pay for diagnostic services and treatment services that were indicated as a result of the screening. So legal advocates over the years have used this statute as a way to look at states' obligations to screen, diagnose, and treat children for medical conditions. There has actually been a coordinated legal strategy across the country of suing states typically around two areas: dental care and mental health care. This case was there have been other EPSDT lawsuits, this was very significant and actually this created new case law. It refined and clarified the obligation of Medicaid programs to cover community-based mental health services for kids.

Medicaid programs start as medical insurance programs, so they were designed to cover medical care. So the debate about what's the proper role of the Medicaid program to cover mental health services parallels the debate we still have about what's the obligation of medical insurance to cover various mental health services. The Massachusetts Medicaid program had covered inpatient care, partial hospitalization, and outpatient care. Then our state was actually a leader in developing diversionary services, or those services that are diversionary to inpatient care- things like family stabilization teams and clinicians who go into the home. They were used to either prevent a hospitalization or to help bring a child home from a hospitalization.

But if you think about it- diversionary is all about an acute episode. So the real heart of the lawsuit was: what's the state's obligation? The Medicaid program's obligation- to provide intensive and comprehensive community-based services in the community for kids with significant mental health needs, who need much more than outpatient therapy and treatment for acute exacerbations of their condition? So they need support and their families need support to help these kids live and thrive in normative regular environments and not have to go into restrictive placements.

As we have said, that was the question at the trial, and the decision of the court was in fact the Medicaid program had *not* met its obligations to do extensive enough screening in the pediatric setting, that there were problems with behavioral health assessments, that kids with significant mental health needs, and there's a lot of literature. Kids and families need care coordination, not just good discrete clinical services, but kids are interacting with a ton of systems. They're working with schools, medical systems, they may be involved with child welfare, and so there is a need for care coordination.

The judge asked both the plaintiffs, the attorneys for the plaintiffs, and the State to give him a remedy plan. He picked the state's plan and one of his reasons was: we couldn't say we couldn't do it, because we wrote the plan. So, obviously, he thought it was a sufficient plan. He did make one change, which was to cut our implementation time-lines in half. Always fun. [laughter] I'm just going to quickly go through what the remedy was. The first was in this area of screening. What we had to make sure of is that all primary care physicians and nurses who see kids on Mass Health must offer to perform a standardized behavioral health screen. We worked with experts to come up with a list of eight instruments that are appropriate for different children at different ages. We say *offer* to screen because it is as with any kind of procedure up to the family to decide if this is something they want to participate in or not. We were conscious of the fact that for some families this was going to be a new experience- having their *doctor* talk to them or their teen about social and emotional wellbeing.

So we selected the tools, we updated all our kind of contracts, we trained providers, and provided a lot of technical assistance to providers. We are seeing some really good screening rates, I think. I'll put an offer out to all of you: we are looking for good programs to benchmark ourselves against. A couple we have in Massachusetts for example in Cambridge, Cambridge Health Alliance, all their community-based health centers use one instrument on a population of kids about 7- to 15-year-olds, and they cover about 70 to 75%. So, one instrument with one particular age group, maybe six health centers, is a much smaller scale. Those are the kind of numbers they are getting, so compared to that we're feeling really good about it. We are trying to find out if there are any other states who have implemented really broad screening. So the responsibility here is for the screening to occur. It is not a diagnosis, it really just is to have a flag stating if there is something here that should be looked into. Then it is up to the physicians, nurses, and the families to decide: Do you refer to a service or do you manage within the pediatric practice?

In addition, there are a lot of obligations in the order just to make sure we got the word out, and we are doing a number of different things. I want to mention one, which is that we have a new family brochure about the new services. They are on the back table, they are regional versions because we actually list providers for that are available in the region, so I encourage you to take a look. You can also order these through our website and the last slide in your packet has our website. You can order them free of charge and you can get hundreds of them.

Okay, so then in assessment there was an issue in the trial that Medicaid could tell the court that we paid for a lot of clinical assessments, but we really couldn't say much more. There was some other evidence at the trial that there was a fair amount of variability in what clinicians do when they do a clinical assessment. So one of the things we needed to do was come up with a way to standardize it. One thing I want to be clear about, we both liked the CANS- the Child and Adolescent Needs and Strengths Tool. One of the reasons we like it was because it asks questions about child and family strengths, it is not only looking at deficits in the in the in the family. One thing to be clear about is that it really does not change what clinicians do in their assessment. It is really a communications tool, it's a way to organize information. It is a way to promote clear communication between different treaters working with the same child, and it's also designed to help clinicians talk to families about the child's condition. It can be used as a tool to inform treatment planning. It helps sort of prioritize the action items. So these are all features of it.

There have now been over 10,000 clinicians trained. You have to be trained and certified to use it. We have built a a web-based system that with the parents' consent, this information can go into it. Which gives the Medicaid program unprecedented information on the kids we are serving. The only thing we know about children we serve, or adults we serve for that matter, are demographics. What you can glean from diagnosis codes in bills and claims, it really doesn't tell you much. This is going to give us the opportunity to track change, clinical change in kids, and to get a sense of risk factors, conditions, and a lot of other different dimensions that we we will have data on.

So then- the services. Again, coming back to this thought of kids with serious emotional disturbance really requires care coordination. The heart of this is something called Intensive Care Coordination. With that is a bureaucratic title we had to get Medicaid approval for. We were the second state in the country to get approval from the Federal Medicaid program for Family Partners, and has anybody here ever heard of the term "Family Partner?" So a couple people. I'll just say, these are typically parents of kids who have mental health needs. They are often women whose children are now grown. These women have developed tremendous skill in understanding our service delivery systems, learning how to have an effective and assertive voice in these systems, and they become coaches and mentors for other parents who are beginning the journey of what it means to have a child with significant mental health needs and how to work with schools and systems with them. It's a fabulous, fabulous tool for engaging families.

One little thing to say is, thinking about mental health policy, our culture is so anxious about mental health and very ambivalent about the field of mental health. So there's an issue of sort of having services there. There's an issue of people understanding what the mental health field has to offer. Family Partners are a critical tool in being a bridge between family culture and professional culture. It can mean it's a little different, you know, they're trained differently, it can be a change for organizations to incorporate family partners, but they are a very powerful addition to the team.

So the other services are Mobile Crisis Intervention, as you probably know we have an emergency psychiatric system in this state. This is an enhancement to have child trained teams who are mobile to wherever the child is. In-home therapy, In-home Behavioral Therapeutic Mentoring. I'm not going to talk about all these services, there is information in the slides about them, and there is information in this. I should also mention there's a companion guide to the brochure for professionals that gives more information on each of the services and how you can access them for clients.

Just to talk a little bit in Massachusetts, the Medicaid program delivers services through managed-care companies. We have had to figure out how to develop these new networks of providers with five managed care companies, and it's really unprecedented the degree to which they have collaborated to do this work. They have created one network that they are managing jointly, which is a huge accomplishment. Just to give you an idea of what's happened since the services came online- Mobile Crisis, In-home Therapy, and Family Support Training came online last July 1st, 2009, and the other services came on through the fall. In the first six months, we have served over 4,000 children with Intensive Care Coordination. Over 3,000 of those kids have also had a Family Partner; Global Crisis over 5,500 kids have been seen; and with In-home Therapy, 4,000.

This is a real outlier, the In-home Behavioral Services. I can tell you it is generally in our experience and our pilot programs a service used by a minority of children. But there is also an issue of people don't really understand what it is yet, because we have more capacity among providers of this service than there is business right now. So we have to work on that. Just to give you an idea, there are a number of different ways we are measuring quality of this system, including that we are just about finished with over 600 telephone interviews of parents who have been involved with intensive care coordination. So you can see some of these.

Let's stick to getting to this idea of using a lawsuit to develop public policy. Luckily our plaintiffs…actually it's an interesting thing- the Center for Public Representation who were the plaintive attorneys in this case, they are preeminent attorneys on deinstitutionalization cases. They were the plaintiff attorneys in the deinstitutionalization of Northampton State Hospital. They have also done a lot of work with children with Autism. They were originally seeking something like Kiddie personal care attendance, the idea of having a paraprofessional in the home to help families. It's not really a therapeutic service but more kind of a supportive service. As they got into this, stakeholders representing families and professionals, the plaintiffs reached out to stakeholders and the stakeholders reached out to them. In the process of this, these attorneys who were not mental health professionals, got educated about best practices in mental health treatment. So they worked with folks who had been involved in this idea of systems of care for children with mental health needs over the past 20 years, based on the CASP principles. Also working with the High Fidelity wrap-around, which I'll tell you a little bit about it. This was very in-line with what Mass Health had been doing. We had been experimenting with pilots since 1995 trying to think of what was then coordinated family-focused care.

Okay, this is interesting. I was looking at this slide and in a way I was thinking that people are going to think this is so old hat, that we have been talking about these values for a very long time. But then I took a closer look; it's very hard to achieve these values. In the Children's Behavioral Health Initiative services, the way the services have been defined, the way our providers are being managed and overseen. The way the kinds of training resources we have brought to bear, and the use of family partners, we are really serious about "family driven" and "use guided," that is a very premium value in these services, and we're really helping people learn how to do that in a real way.

Community-based- this is really having the sort of services with sufficient intensity to keep kids in the community and out of restrictive settings. Culturally competent- we are making a baby. We are at the beginning, and one of the things we were able to do was to select three providers of Intensive Care Coordination who specialize in serving particular populations. We wanted to bring a kind of expertise into the provider community. We selected Gandara in Springfield, which has a long history of working with the Hispanic community in in Western Mass, also Children's Services in Roxbury in Boston, and then the Walden School working with deaf kids and families.

Okay, these are going to be familiar to everybody, these principles. Ways that we are incorporating these principles into the new services, obviously behavioral health screening is about early identification, which can promote early intervention. CANS assessment is a way of really looking carefully at the individual strengths and needs of a particular child and family to help achieve truly individualized care. And intensive care coordination makes a best practice in care coordination available.

How many people have ever heard the term "high fidelity wraparound?" Okay, there is a website on the last slide that I gave you that is the national best practice site and it's called the National Wraparound Initiative. There's a really terrific short article on that website about the history of wraparound. It goes to some cool Frenchmen in France figuring out some stuff, and a whole lot of really interesting innovation that started really about 30 years ago. It was a combination and I'll just say this is a gross simplification, but very creative practitioners in the field, and one of them is a man named John Brandenburg, who is training our providers in how to do High Fidelity Wraparound. He was in Alaska, which for a long time has had a lot of oil money. They tended to send all their kids with serious emotional disturbance to residential treatment schools in the lower 48th. He, with some other people, started a project of kid-by-kid bringing them back home to Alaska with very innovative interventions. I mean it's kind of silly but it's true, it's what they did, he says he recruited hairy gorillas, and these were big guys who would take teenagers fishing. So you see it's looking at appropriate supervision, good relationships, normative activities, you know, things that can actually help kids instead of taking kids out of those activities and sequestering them.

So there were these sort of whacky people out there who were doing this interesting community-based work. And then a similar thing that was happening was the political empowerment of the parents of children with mental health needs. I think this is obvious to you all that parents of kids with mental retardation were politically organized decades before parents of kids with mental health needs, because they were the problem, right? And that was really the conventional wisdom for a long time and in many cases still is. So about twenty years ago, I mean it's a very interesting history, but it coincides with the sort of innovation in the provider community with a movement among parents to demand something else. And part of that was a demand to have kids at home and not taken away, but also to be listened to as experts on their kids.

I think one of the hallmarks that really attracted me to wraparound when I first learned about was that there was a very genuine honoring of all of the expertise around a given table. The doctor gets honored, the parent gets honored, the relative or you know friend of the kid, and the DCF worker, everybody is respected as bringing something important to the table. It really is this values-base that is enacted in this process, it's a very structured process and everyone, professionals and parents, are coached by the care coordinator to approach this in a strength-based way. So it doesn't use the words appreciative inquiry but it's very much in that spirit of, what does everybody bring to the table that we can build from and really not spending a lot of time in meetings together getting mad at each other. You know, there's a place for those feelings to be dealt with and they are, but it's very interesting. So over the years, this has developed into a very structured process. There are four phases, there are ten principles, again you can get more information about that on the website.

We have talked about Family Partners. So just some reflections I'm going to talk about, if you don't know this already it's really important that you know this. Our Federal and State budgets are structurally out of balance. What that means is that the costs of government grow faster than revenue cost. Now we've been aware in the last 7 years, we have had a terrible downturn so we keep having to cut the budget. Well, ever since about 1990 even when we don't have a terrible downturn, we're managing a $500 million to a billion dollar shortfall in the budget. This is primarily driven by the cost of health care, through programs like Mass Health. It takes up a greater and greater portion of the budget. It's really just medical inflation is higher than economic growth. In our state, we have an issue too that our tax structure has not kept in line with where our economy is going. So our revenue growth is actually less than our economic growth. As more of our economic growth is in the service sector and we don't tax the service center in the same way. This puts pressure on every governmental activity.

So what I want to say about insurance companies, it's really, really easy to think they're the bad guys.

Audience Member:

They are.

Emily Sherwood:

She says they are [laughs]. I will just say this: they are our society's mechanism for trying to manage cost on behalf of payers. The payers are us in public sector programs, and the payers are employers and also us through our wages. So we've got this mechanism, we're trying to manage cost, we really don't know how to do it, and it's not getting at fundamental issues. I mean, really we have got to fundamentally grasp what we're doing on healthcare in this country. Basically it's sucking up the resources for everything else. So you know I'm not an expert expert in this area. I know more than the average Joe but, you know, you can have a very in-depth discussion. But this is just very important for those of you who care about public policy to understand why things are so tough.

I had the benefit of starting my career in 1985 in the legislature, there was 5 years where there was actually revenue growth, and the fight in the budget every year was like, who in leadership was going to get to have their project funded? But that really ended in about 1989 or 1990, and then what's happened is you also have a robust political debate since the Reagan-era about, what is government? What do they know how to do? They don't know how to do much. They seem to mess everything up, and so support for government and for taxes was low. This has had an impact on provider organizations, as they have been stretched and underfunded now for decades, and it's had a real impact on the strength of organizations.

So litigation is now one of the very few avenues left to get substantial service expansion. There is no governor who could get elected or paid for saying, "I'm going to spend $250 million (which is what CBHI is going to cost when it's fully rolled up) on 10,000 kids." You can't do it. Because you have got to raise taxes and it only helps 10,000 kids. Now the issue is, you can only do litigation where you've got strong statutory entitlement. So you end up in your state budget with pockets of protected populations and unprotected populations. That's why the Department of Mental Health programs keep getting hit. In our state budget about two-thirds of the budget cannot be cut, in part because of entitlement programs like Medicaid, Special Education funding, contracts, and labor contracts. So you end up cutting a third of the less well-protected parts of the budget, which means state-funded programs for kids, and state and even Medicaid services for adults who don't have the same protection of the EPSDT statute. So just to be clear, states constitutionally cannot run deficits the way the federal government can, so when you have no revenue growth and you have a lawsuit, you cut other programs to pay for your obligations under the lawsuit.

Now this has an effect on our political institutions in that it reduces the discretion of the Legislative Body and of the Executive Branch managers to figure out how to manage you know, all the needs in what we have. Then there's an issue for example in CBHI where we know we have to appropriate to pay for services. Well, there's a lot of other things we need to be doing to make sure that this big huge service launch goes well, things such as training and technical assistance. We've been lucky we have gotten support. I worry about how soon the pressure will come to cut those resources, and this is a big service change that's going to take support over time.

The good news is that litigation can propel very major systems change. It's an inherently very formalized and adversarial process. One of the things I'll say when I started this, I was spending about 30 to 40% of my job is meeting with the Court Monitor, meeting with the plaintiffs, going to court, filing reports with the court. It's now about 60 to 70% of my time because now that we're actually implemented, there's a lot more things to fight about. The state paid the plaintiffs for the whole period of the litigation those multiple years of litigation. You paid $7 million for that. We just got another bill this year for another $2 million, and I'm going to refrain from saying anything more. We have a fantastic monitor, a monitor is a very necessary thing. That costs about $500,000 a year. She's going to be doing a case review. That's part of her monitoring activities, that's going to add another $200,000 for that this year. We don't have new money. That's going to come likely out of training resources or other resources.

So the headline of this- litigation is costly, difficult, reduces innovation, reduces discretion, and can produce rapid and far-reaching systems change. It is currently one of the very few viable options for program expansion. So here's our website through Mass Health. The easiest thing to do is just go to the Mass Health landing page; there's a big button that says CBHI, and there's all kinds of materials. This is the partnership website. This is where the most up-to-date lists of providers of the new services are, and that is the National Wraparound. [applause]

David Satin:

Thank you. We have gone from the complexities of policy development in the legislature to the complexities of policy implementation in the field. Lots of good ideas, good plans, important needs to fit into a hodge-podge of budgets and pressures. I'm reminded that somebody once said, "If it's all clear to you, you don't understand the situation." [laughter]

One of the major concerns is the the discoordination, the lack of a system of ideas and implementations. There are good things here, there are moneys there, there are court orders here, there are legislative mandates there, but how do they meet one another? A major underlying issue is the balance between needs and resources. In this society, famously, our needs are great and our resources are some place else, and we don't want to match them up. It leads to a lot of innovation and a lot of creativity, but the creativity of trying to make things match when they're not meeting is keeps ones up oneself up at night.

Peggy Kaufman, MEd, MSW

Training Institute, Jewish Family and Children's Service of Greater Boston; Clinical practice, consultation, and supervision

Introduction by David G. Satin, MD

Now we get to the point of seeing how this works out in a real life child mental health service situation. Peggy Kaufmann is Director of the Center for Early Relationship Support and Patient Programs at the Jewish Family and Children's Service of Greater Boston as well as of other children's and family service programs in the past. She is academic instructor in the Infant Parent Training Institute of the Center for Early Relationship Support at the Jewish Family and Children's Service. She is also, in her spare time, engaged in the private practice of individual, family and group psychotherapy, and consultation. She also conducts training programs and presentations. She's really in the practical applications business. She earned the MSW degree from Smith College School of Social Work, and a M.Ed. degree from the Bank Street's College of Education. She's a member of many organizations and boards, including the Massachusetts Association of Infant Mental Health and the World Association of Infant Mental Health, and she will help us to understand how the care of children and families proceeds under public policy.

Peggy Kaufman, MEd, MSW

When Emily came up here, she saluted Ruth, and I have to say that I first heard Emily speak when she was in the earliest stages of her implementation phase. And congratulations! I remember sitting at that meeting, it was a statewide meeting, and thinking, "Thank God I'm not Emily." [laughter] So fortunately, we had Emily here in our state. So I am privileged to be here at MSPP where I work with others on our faculty at the Infant Parent Training Institute teaching an infant and toddler course with Fran Mervyn-Cohen, and also with the Boston Institute for the Development of Infant and Parents, which now is a partner with MSPP.

This afternoon it is my charge to speak about services, specifically services that foster the emotional health of children from the earliest start. So I'm going to shift a little bit and go to the more micro level- and through narrative storytelling and the lens of promotion, prevention, and intervention I'll share with you the services that are offered for children at the earliest time in the mother-baby relationship. These are the Interconnected Services of the Center for Early Relationship Support, a Jewish Family and Children's Service of Greater Boston, where the goal in all of our work is to have the greatest impact on the mother, her infant, and their relationship– really at the very source, trying to promote and prevent the spiraling stresses that we're hearing about now.

The Center for Early Relationship Support, is now 21-years-old, and the theory and research that shape and inform these services are among others, attachment research, the research of mentalization, brain development, emotional availability, and the impact of a maternal depression on children's growth and development. As I present these stories to you, I'll be referring to a number of services on this chart. In my limited time, however, I will not be able to address all of them, so I will gladly talk about them in our discussion or after this symposium.

I would just like to take a moment for us to consider the building blocks of young children's mental health. This is not by any means an exhaustive list and does not include some of the external conditions. This list is presented with the understanding that concepts are subject to a personal and cultural perception. So the mental health of parents and caregivers is a critical building block. Safe, nurturing, enduring relationships, consistent, responsive care-giving, an environment that fosters regulation and appropriate expression of emotions- ones that match the sociocultural expectations, and appropriate stimulation and opportunities of discovery with structure and limits. So I'm going to begin with promotion. Promoting positive parenting practices, healthy child development, awareness of the full range of mothers' and infants' needs, and building a community of support.

Clara was one of the mothers in the Centering Pregnancy group at Joseph Smith Health Center, one of our partner organizations. The Feeding Support Team of the Center for Early Relationship Support comes to our center center Centering Pregnancy group to provide anticipatory guidance around feeding and to introduce the services of the Center. So I just have to say for those of us not familiar with "centering pregnancy." These are groups that start early in pregnancy and they may start in our neighborhood health centers or in midwifery practices, where the pregnant woman and her partner or the pregnant woman alone comes for her regular checkup at a given time with a group. So this group meets monthly and then later on in the pregnancy more frequently, and it's not only childbirth education, it's health checkups, it's an opportunity to talk about nutrition and to prepare, which so little preparation is given to women and to families, to prepare for um the uh the the the postpartum period.

So we came to this group to present our feeding support services and met Clara who was in attendance. After her baby's birth, she received a newborn welcome visit from the staff of the health center, who also run one of our support groups for Spanish-speaking new mothers. Now I keep mentioning one of our partners and I just have to say, and I brought with me a packet that Clara received when she had her newborn welcoming visit, and it is filled with information about community resources, everything from literacy programs to women, infants and children, back to sleep, and nutrition, and these are all in Spanish, everything in this packet. So whether it's JF and CS's Welcoming Baby Program, or it's the Joseph Smith Newborn Welcoming Program that we work with, or it's the the Family Nurturing Center Program out of Dorchester, who does the welcome baby visit, we're all working together and trying to organize and orchestrate our efforts so that we can serve as many families who are having new babies as possible.

But Clara learned about our New Mother's support group for Spanish-speaking new mothers in her newborn visit. She had been in the United States for over 6 years, but her life had been centered around her two jobs to make ends meet and the struggle she had with her boyfriend, the father of the baby. Clara started attending our new mothers group when Manuel was 3-weeks-old. She continues to attend and he's almost 5-months-old. Once every month, the group goes together to the diaper delivery program at the church, where our group is held. Last week, several moms went on a field trip with funds provided by a small grant. Actually, next Friday, they're going on a duck tour. We had some funding from the Early Childhood System of Care in Allston and Brighton, and we asked the group what they would like to do. They said, "Well you know, sometimes we see these duck tour boats and really wonder about them," and many of the moms had actually never been to Downtown Boston. So that's happening next Friday.

In addition to the weekly support group, the leader invites guests such as nurses, domestic violence specialists, WIC staff, and infant massage teachers. In keeping with the cultural tradition of many of these mothers, the group begins and ends with singing, birthdays are celebrated, and baby-naming celebrations are shared. Our hope is that Clara and Manuel will grow together with this group of mothers and babies, even after their babies outgrow the group when they are walking. So when you become mobile, you graduate. But our partnerships, with other organizations throughout Boston including family networks, offer playgroups and activities to keep these mothers in connection. So promotion is starting to build a supportive community and putting services, including basic needs and resources, in place from the earliest days, at best, before birth.

This group is one of 12 weekly support intervention groups that we conduct 52 weeks a year. Other groups include those for women suffering from postpartum depression, mothers of young children whose own mothers are deceased, mothers of young children whose own mothers provided no positive model for mothering, we call that mothering without a model, feeding support, sleep support, and mothers of multiples, to name a few.

And now prevention. So our prevention services work to prevent the spiraling stresses that can derail the mother-baby relationship from earliest days. Maternal depression is the most common port of entry to our services. Maternal depression may leave the mother more withdrawn from her infant, less likely to demonstrate positive affect and sensitivity among other interactional difficulties. Maternal depression strains the attachment process, impairs social-relational learning and development, and interferes with the infant's self-regulatory abilities. From the Center for on a Developing Child and I quote, "Children who experience maternal depression early in life may suffer lasting effects on their brain architecture and persistent disruptions of their stress-response systems." Depression and isolation are the primary doors into our prevention and intervention services. The following narrative is a focus on prevention.

Rita's baby was born at 31-weeks-old. After years of fertility treatment, she conceived at the age of 41. Rita believed the conception was the end of her challenges. However, her daughter spent 6 weeks in the NICU and had multiple medical interventions following brain bleeds and respiratory distress. The NICU social worker contacted our Center to connect Rita with our premature baby-family liaison, Parents Of Premies. In addition to the stress she was feeling trying to balance her return to work with visits to the NICU, she was becoming increasingly anxious about the baby's return home, her ability to cope, and the baby's uncertain health trajectory. Our premie family liaison made 3 visits to Rita in the hospital NICU before the baby was discharged, and continues to visit weekly to teach Rita about developmental expectations. Rita's expectations of her baby's developmental capacities were unrealistic, and she was slow to understand the concept of adjusted age.

To learn together to read and understand her daughter's signals and cues, the family liaison also taught Rita infant massage and connected her with other supportive services, including Early Intervention Program in her community and visiting Moms, which is our Mentoring Community Moms. The premie family liaison introduced Rita to her visiting mom, a community volunteer mentoring mom, who is herself the mother of an older child born prematurely, a bit like Emily was describing about her Family Support Workers. Her visiting mom visits weekly to provide support, nurturance, and guidance. I just want to say that all of these visits are first made by a clinical staff who does screening and is then followed by the clinical staff. The Mentoring Moms go through an extensive training and are required to come to supervision for two hours every other week. So it's way beyond that, just going into a home to provide nurturance and support, they're very carefully supervised by our staff.

The Visiting Mom will stay with Rita for the first year of the baby's life. When Rita's daughter was able to go out in public, Rita began to attend our Fragile Beginnings Support Group for mothers and babies born prematurely. We don't know what might have happened had Rita not received the services of CBRS when she did. Rita had worked full-time until her daughter's birth and after until daughter's homecoming. Rita is an older mother who had no motherhood network. Her own self-care capacities were suffering at the time of our involvement. The NICU social worker had expressed her concerns that Rita was quickly becoming overwhelmed and exhausted by her circumstances. Our Visiting Moms are trained to be watchful of the slippery slope of post-partum depression for when more intervention or treatment is needed.

Our intervention is a dyadic intervention. Addressing the crisis that post-partum depression and/or challenges in the infant/toddler behavior present for the mother, infant, and family. The intervention using best practice from developmental health theory and tested interventions, such as those of Frieberg, Lieberman, Slade, and others, is aimed to pre-improve maternal mood and the parenting experience and the relationship with her baby.

Jemma was referred to our therapeutic intervention- it's called Early Connections- by the midwife at her neighborhood health clinic. At the time, she was withdrawn from her daughter, frightened by her baby's cries, sleep deprived, and attributing multiple negative attributes to her 6-week-old little girl. Jemma has lived in Boston for 8 years, arriving here shortly after a gang rape, which she is reluctant to talk about. Her mother left her at age 4 to seek a better life in the States for Jemma and her four siblings. They were left in the care of their grandmother until Jemma was 7, when her grandmother died and the children were sent to live with an aunt, who provided the children with only very basic care in a punitive environment. Jemma was 18 when she finally was reunited with her mother. The father of the baby is Jemma's mother's live-in boyfriend.

The work with Jemma and her infant has progressed over the last 8 months. With the complexity of Jemma's own trauma history and early abandonment, there is still much to be done to continue to get their relationship back on track. And our intervention includes among others: understanding the baby's experience; helping the parent to be able to keep her baby in mind; to begin to see the connection between things that are happening and how the baby is responding and reacting; to develop the ability to reflect on the baby's needs, feelings, his or her mind as well as her behavior; and to recognize the emotional needs and to respond to them in a sensitive way. In order for the mother to become more sensitized to her baby's emotional cues, she must develop the capacity to observe and monitor her baby's affective experiences, and to be able to recognize that these experiences influence behavior.

When Jemma leaves for work in the morning, her now 10-month-old baby, becomes extremely distressed. Jemma has learned to understand that this behavior is about her feelings of separation from her mother, among other feelings. If you think about Jemma's early history, this was not part of her repertoire. Unable to tolerate her baby's cries, Jemma would slip away. However, now she talks to her daughter before leaving, to prepare her, she reassures her that she will return, often gives her some kind of transitional object, and passes her to her caregiver as her cries have reduced to whimpers. Her daughter's wails sent Jemma's body into heightened anxiety, and Jemma would do anything to avoid her own dysregulation as well as to avoid her daughter's cries.

Another intervention is of course regulating feeling states, as I said, helping both parent with the infant, learn new ways to manage difficult feelings. It begins with identifying and naming feelings, noticing affect, effects and responses, building ways of calming and soothing self and baby, to build shared experiences of pleasure and connection, finding and facilitating new forms of being together that include playfulness and the experience of relationships being sources of positive feelings, enlarging the space in which to become a good-enough mother. Repairing relationship disruptions, the work of Ed Tronick, finding opportunities to repair experience of disconnection, misunderstanding or conflict in relationships, both between mother and baby and between mother and clinician. Linking past and present experiences and helping the mother see the connection between her difficult current behavior and feelings and experiences in the past- her ghosts- as well as mobilized experiences of positive relationship- the angels, like her grandmother- to facilitate present coping and comfort. We think of this relationship-based attachment and practice where we hold the mother in our minds so she can hold the baby in her mind. We have come to appreciate the power of therapeutic holding environment for it's intergenerational impact. And as we offer an experience of safety, of being remembered and of being known, maybe differently than the mother knows herself, we make it more possible for the mother to offer these gifts to her baby. We are holding in mind the mother as we are seeing and hearing her, but also the mother we hope and believe she can be.

As you were hearing, all of the above are home-based and community-based services, but primarily home-based. Our interventions take place in the home. Home visiting programs are proliferating and gaining greater recognition in State and National arenas. Evidence-based, longitudinal studies are giving enhanced credibility to the delivery method. Government investments and home visiting programs are seeking-seeing growth and funding opportunities. As in the case of Rita and now Jemma, neither would have been able to get to an office-based service. Rita, home with a vulnerable premie, and Jemma, paralyzed by her own anxiety, could barely get out to their children's well child clinical appointments, no less to a mental health intervention.

Over time, Jemma's anxious preoccupations have decreased, thus increasing her attunement to her infant's needs, increasing pleasurable interactions, and she's developing confidence in her parenting abilities. Jemma's own history cannot be eradicated but our hope is that we have changed the intergenerational cycle of trauma and given her daughter and their relationship a better start. When we make a change in the mother-baby relationship in the first year of life, we change everything. When postpartum depression goes untreated, there's a greater risk of recurrent postpartum depression and non-postpartum depression. There's an impairment in mother-infant attachment, increased infant anxiety, impairment in cultural, social and behavioral development of her offspring and increased risk of depression, anxiety disorders, and substance depression in her children. Let me just share a couple of the voices:

> "There was this scary wall between my son and me."
>
> "I know that my baby is smiling at me because she has just succeeded in torturing me." This was a 6-week-old.
>
> "I'm afraid to touch my baby because I feel I could be poison to her."

When we pay attention to these voices, we know that time is not in our side, and again from the Center on Developing Child, by intervening early we increase the likelihood that children of depressed mothers will grow into healthy, capable, fully-contributing members of society.

So last I just want to share with you a little bit about the ways that we as a small agency connecting with other affiliations within the Boston community, the national, and the international community, are trying to disseminate the model and are pushing the agenda. We have at our Center at Jewish Family and Children's Service and Infant-Parent Training Institute, which provides ongoing training in this field of infant mental health, and I'm happy to say that a couple of our graduates are are here in the room. We are part of the National Child Trauma Stress Network Zero to Three Taskforce. We have presented and will be presenting this December our work and research at Zero to Three. We have presented our work and research findings at the World Association of Infant Mental Health in Amsterdam and in Paris. Our our programs and research have been published in the Infant Mental Health Journal Zero to Three, Families and Society, and the Archives of Women and Mental Health. Our programs, particularly the Mentoring Mom's program, has been replicated in the U.S., Israel, and Australia. We are part of the learning collaborative here in Boston of Project Launch, a new SAMSA funded grant, We're part of the Connected Beginnings Training Institute here in Boston, and are working to pass the Bill for universal postpartum depression screening and are certainly active with our Department of Public Health in pressing their agendas in maternal mental health. So, thank you and I look forward to continuing the discussion.

David Satin:

It's overwhelming. The size, the basic nature of the problems, and the changes and the growth that's needed that are being addressed in this agency. And this I gather is the kind of basic needs that meeting them is being enabled by these policies and these coordination of resources. And one shudders to think what would happen, and what *does* happen when these kind of needs are *not* addressed. When things go untreated and uncared for.

Marylou Sudders, MSW, ACSW

President and CEO, Massachusetts Society for the Prevention of Cruelty to Children (MSPCC); Former Commissioner, Massachusetts Department of Mental Health

Introduction by David G. Satin, MD

We come down, back to the community. Mary Lou Sudders is President and Chief Executive Officer of the Massachusetts Society for the Prevention of Cruelty to Children. Previously, she was Commissioner of the Department of Mental Health of the Commonwealth of Massachusetts. She received her Master's degree in Social Work from Boston University and serves on the Board of Directors of the National Alliance on Mental Illness of Massachusetts, the Massachusetts Association for Mental Health, and the Children's Behavioral Health Advisory Council. She was awarded the Doctorate in Humane Letters from the Massachusetts School of Professional Psychology. She will tell us about the role of community advocacy groups in seeing that the mental health needs of children and youth are met, both initiating some of these policies, and responding to what the outcome is and how satisfied the community is with these policies.

Marylou Sudders, MSW, ACSW

Good afternoon everybody. It's a pleasure to be with you. I have been sitting here totally rewriting all of my remarks because all of my lines have been taken. My dear friend, Representative Balser told our story around advocacy and agitating for change around children's mental health policy, the professor told my Dr. Lindemann story about the creation of the first community mental health center in the Commonwealth of Massachusetts, my dear friend Emily has really explained sort of the implementation of services and systems change as a result of litigation, and Peggy talked about the incredible importance of early intervention. So, with that, I do take all that we do very seriously, and on a Friday afternoon I tend to be slightly irreverent. Because it's always good to know that I'm still standing, taking nourishment, and a week has gone by and I have not been sued.

I did want to start, though, with just a brief homage to Dr. Lindemann. I was honored for seven years to be Commissioner of Mental Health and the offices of the Commissioner are actually in the Erich Lindemann Mental Health Center. So every day I actually had the opportunity to reflect upon the importance of community mental health and why that needs to be so important to each and every day of a public official. Dr. Lindemann was a pioneer in the development of the community mental health center approach. The days of asylum moving to truly integrated community mental health services, and in fact what Rosie D. v. Romney really was about was the creation of Erich

Lindemann's vision if you would of truly creating a community-based system of care for children in the Commonwealth of Massachusetts that is high quality and supports not only children but their families.

Community mental health is also about prevention, early intervention, access, and the importance of consultation to schools. The best public policy is shaped by public discourse, debate, and negotiation. I'm actually, both as Commissioner of Mental Health and now as the President of MSPCC, I was always honored to be able to sit at the table with individuals who had different perspectives. I'm a social worker, I am a family member, by that I mean that mental illness runs throughout my family, so I also have a family perspective. But when I was Commissioner of Mental Health, I sat at the table with individual adults with mental illnesses, families, parents who had children with mental health disorders, psychologists, social workers, nurses, with sort of the messy voices that make up if you would mental health. But it was truly um by sitting at the table and honoring each others' perspectives, that I truly believe some of our best sort of legislation during the seven years that I was privileged to be Commissioner of Mental Health came out.

Actually the first round of parity, which was not the best piece of legislation, I would never say it was the best piece of legislation. But in fact, it was the first time the Commonwealth actually had changed the commercial insurance laws for mental health since the original mental health commercial coverage went into place which was 1978, which was for those of us who are old enough will remember that $500 outpatient mental health benefit, which was then later to be interpreted to be 8 sessions maybe 12, depending on the commercial insurance, right? Well that was what we had as the *minimum* mandate in the Commonwealth of Massachusetts, of course every commercial insurer interpreted the minimum to be the maximum, one of those things that I learned about laws and how you write legislation. But in fact in 2000, we changed and created a new platform for commercial mental health insurance, certainly not the best piece of legislation, it was a compromise piece of legislation, which often legislation can be. But it created then the platform for what happened in 2008, when there was much more progressive thinking within the Legislature that would embrace sort of a broader coverage for mental health disorders.

The same thing is very much true on the Children's Mental Health Campaign. I truly *believe* in collaboration. I truly *believe* in sitting at the table. Some people would say I'm a slightly strong personality. Of course I think I'm shy and retiring, but I like to sit at the table with the many different voices that represent either struggles, opportunities, challenges, and different ways of thinking about mental health to come up with an advocacy agenda. So I truly believe that the best public policy is shaped by public discourse, debate, and negotiation.

On occasion, as you've heard a little bit about today, the courts take action when either the public will is lacking and there's an obvious wrong that must be righted. Rosie D. v. Romney has provided that lightening rod of change for children with serious emotional disturbance who have Medicaid. But it's also my hope that together we seize that opportunity to provide high quality mental health care for *all* children of the Commonwealth. Nothing less should be acceptable, and that was really the backdrop to the Children's Mental Health Campaign, which I have been proud to be sort of a troublemaker behind.

I do actually like to think of myself as an agitator. Of course, you know, I have had great privilege of agitating with these incredible people up here. If Peggy hadn't said it, I was going to actually remind people about Representative Story's bill around postpartum depression and universal screening which is currently before the legislature. You know what, we'll be back next year. That's my attitude about these things, you know. We're like…okay, I'm sort of like that Ms. Pacman, hit the bump, back up, come back another year, because that really is what advocacy is about.

But you know when we think about children's mental health systems, the reality is that there is no one system, as Emily said. For children are in schools, communities, and their homes. If they have a serious illness, they may be removed from their natural communities for a period of time for specialized treatment, but the idea is that they will eventually return home to their schools and communities. The days of utilizing long-term hospitalization and separation in places such as Gabler or other long term placements, has really been replaced by creating a system of community-based systems of care. And I'll be the first one to stand up in front of you and say that right now it's a mess. I don't mean that in a bad way. What I mean is when you go through this kind of massive systems change it will often feel worse for a while, because it's so quickly changing. It is a truly a paradigm shift, not just clinically, but in terms of parent partners at the table, of parents truly being the person asking the question, as opposed to sort of the doctor sort of taking charge. You know that's tough stuff, it's sort of like everything is shifting. Of schools being really asked to be able to manage children who in the past would have been removed from the school system, of the acuity shift, so as practitioners in outpatient settings and in other community agencies, sort of what hospitals are really used now for stabilization, and outpatient providers are really sort of managing much more acuity in their practices.

All of this is sort of that messy kind of change that happens before we will have a period of stabilization and some, maybe there might be some period of homeostasis in mental health. I'm not sure about that, but you know but things will sort of settle a bit, so right now we are in that massive period of change. It is dynamic, it is challenging, and I know I see the end of the tunnel. You know I see that opportunity, that the 100,000 kids with serious emotional disturbance in the Commonwealth of Massachusetts will get the services and supports that they need, that their families will be honored at the table with practitioners and by school systems, so that they're not blamed for the child's illness, but they are seen as part of the system to help support their kids. Because, as we all know, as all of you know who are practitioners in the room, that if a child is in crisis, a family is in crisis. You can't just individually treat that child, without truly understanding what's happening in the rest of their systems.

So when people say well that Kids Mental Health System, what I like to think about is a membrane, or a safety net if you would, of mental health services, that overlays our communities and families, to provide the services and supports that a child and their family needs, in order for the youth to manage their systems and to develop the coping and adapt- adaptive skills to be successful. In order for that safety net or membrane to be successful, it must provide for the full range of high quality treatments and supports. It must connect the mental health world with the places where youth are, such as schools, and where they often receive their care, which is at pediatric offices and community health centers.

You know, if your child started to first have some behavior happening, or something happening to them, you don't usually pick up the phone and call your local community mental health center. I might *like* you to, but that's probably not where you first make that phone call. You go to where you you have trusting relationships, your doctor's office, it might be your clergy or your rabbi. It's probably not picking up the phone and calling that sort of community mental health center. So that is why we need to bridge mental health with the places where kids and families are.

So three and a half years ago, as Ruth stole my story, Children's Hospital and MSPCC came together with a white paper, I actually brought a copy, which you can pull down from wwmspcc.org. It's not an academic paper, you will not find it in a professional journal, but it's a white paper, and it's called Children's Mental Health in the Commonwealth: The Time is Now. Well we firmly believe that the January 2006 decision by U.S. District Court Judge Ponser was the catalyst for substantive change, particularly for kids with Medicaid, it's really important to remember that the Rosie D. v. Romney is a Medicaid lawsuit. It also served as a call to action for all children needing mental treatment and support, regardless of their insurance status. Because the reality is that more kids in the Commonwealth of Massachusetts have private insurance, not public insurance.

But how did we get here, so how did we get to this this advocacy, this Children's Mental Health Campaign? Well the state of the kid's mental health system, you've heard some of the statistics, including one that Dr. Covino took one of my lines. In Massachusetts more than 140,000 young people need mental health services, but of these children more than 100,000 do not receive the services they need. The number of children with mental health needs is greater than the number of children with leukemia, diabetes, and HIV/AIDS combined. Nationally, 20% of all children and adolescents, so that's 15 million, have a diagnosable mental health condition, and 1 in 10 of these children and adolescents suffer from a mental illness severe enough to cause significant impairment, and Massachusetts has the notable distinction of having one of the highest rates of expulsion of children from preschool settings and early education centers because of behaviors.

The effects of the problem: nearly 50% of students with a mental disorder drop out of school, it's the highest dropout rate of any disability group in the Commonwealth of Massachusetts. Ninety per cent of children who die by suicide have a diagnosable and treatable mental disorder at the time of their death, and suicide remains the third leading cause of death among young people in the Commonwealth of Massachusetts.

Of youth involved in state and local juvenile justice symptoms, 70% suffer from mental disorders, with 20% experiencing symptoms so severe as to impair their ability to function. And according to statistics by Probation, if you trust Probation, the number one reason families seek CHINS is to receive mental health services for their children and adolescents. So can you imagine as a parent, being willing to give up custody of your child by going to court in order to receive mental health services? And in fact the Mom that Representative Balser was referencing, who sat with Speaker DiMasi, first went to file CHINS for her child and she actually had no idea what it was. Actually, it was a school psychologist who suggested that perhaps a way to increase her access to mental health services for her very ill child was to file a CHINS, and she had truly no idea that what she was doing was actually giving up the custody of the child she loved in order to receive mental health services, and then spent 6 years getting her child out of that custody situation. And this is someone who, as Ruth said, was well educated, thought she knew the system, had insurance, and found herself in this maze of a system.

So that is how we started to advocate and agitate for change in the Commonwealth of Massachusetts. Since clearly I was an abysmal failure as Commissioner of Mental Health trying to improve the children mental health system, apparently I had a better shot outside the system. So the five broad themes of the campaign is that:

1. Massachusetts must create coherent mental health policy, have dynamic state leadership in order to ensure access to culturally competent, linguistically appropriate, and effective mental health services for all children in need.
2. Children much have access to culturally competent and linguistically appropriate early identification and prevention services.
3. Private insurers must be required to play their part in addressing this crisis.

4. Special emphasis must be given to the implementation and delivery of mental health and substance abuse services to youth in state care or involved with the state juvenile justice system, and that;
5. Children's mental health policy in the Commonwealth must be based on current knowledge of children's mental health and promote culturally competent, linguistically appropriate, evidence-based standards.

That's what the Children's Mental Health Campaign is about. The Steering Committee is the Children's Hospital Boston, MSPCC, PAL, which is a grassroots organization representing families who have children with mental health disorders in the Commonwealth of Massachusetts and an incredible voice in advocating on behalf of the needs of children and families. And then also the Health Law Advocates and Healthcare For All.

You know, we were lucky. Any of you who want to be an advocate, you can have the best idea, but if the environment isn't right, it is difficult to shape the environment or have the environment ready to hold that conversation. We had perfect timing- you had the Rosie D. litigation, we came out with our paper, but Massachusetts had just passed a Healthcare Reform. And when I would spend time with them, I would go up and talk to legislators, and Lisa Lambert from PAL would go up and talk to legislators about mental health for kids. You were lucky if you got to sit with Representative Balser and some other individuals, and the fact that there was now a committee on mental health and substance abuse, because these were folks who were really primed to hear your issues, but think of all the things that come before a legislator, I mean you know everything from you know potholes to local aid to schools to mental health.

And you know mental health is complicated. We talk about it sometimes in words that you can't necessarily find in Webster's Dictionary. I mean there are times I have said to folks, I could probably talk in acronym all day long if I wanted to. It's a tough conversation sometimes, but I remember Fred Berry who's a strong proponent of mental health issues and he's now the Senate Majority Leader. I remember Fred once said to me, "Marylou, mental health is just so complicated!" Well, after we passed Healthcare Reform in Massachusetts, give me a break! I said, "Come on! If we can pass Healthcare Reform in Massachusetts, are you telling me we can't do something about children's mental health?" And you know it was fascinating, it really just started to frame that conversation. So it created an environment.

And Healthcare For All was so important to us. That why it's always good to make sure you pick your partners in advocacy to know what everyone's role is. Healthcare For All is the group is the external group to the legislature that really shaped the dialogue in what became the Healthcare Reform Law in Massachusetts. We tapped them to be our partner to help shape the legislation and the conversation around kid's mental health. So we were lucky, of course I would tell you it's because of our incredible planning and our writing legislation. But really the environment was right for this conversation. We were channeling anger sometimes, we were channeling hope, and we had strong legislative friends. To have a Speaker of the House say that mental health was long overdue…Whatever you think about his politics, I mean what legislator will talk about mental health from that kind of leadership platform?

So the kid's mental health campaign is a 5 year campaign, which is a really good thing, because legislation is hard to get passed, and we have 95% of the Bill was passed in its first year when it was filed so we were like, "Oh! well that's amazing!" But we think of it as a 5 year campaign, because if you think that getting legislation passed is hard, implementation is even harder, which is what Emily is flogging away at each and every day, I mean implementation of this kind of systems change is tough.

And I'm starting to think that the next two years of the campaign is really should be labeled, instead of The Time Is Now, which was the name of the campaign, but as I think about the next two years, I'm thinking more that we should be calling it Enrage and Engage, and I'll get to that in a second. The reality is that when it comes to children's mental health, the public system has been the driver for change. We don't often think of government as being the innovator of change, right? We think of academia, we think of research institutions, we think of the private industry as being sort of incubators of change, but not government. But government is the leader of change when it comes to both Medicaid funding of children's mental health services and on thinking about mental health systems. Now it's absolutely true there never are enough services to match the need, but it is the public sector that is driving the thinking of change around children's mental health and the financing of it.

The private insurers, and I am sort of picking on them. They are lagging behind and in some cases significantly. I'm sort of doing this quickly. In my current life, among other things I get to do, is co-chair the Insurance Committee for the statutorily created Children's Mental Health Commission. I have just finished interviewing the major private and public insurers in the Commonwealth of Massachusetts. What I heard was very troubling on several fronts, of which I will mention a couple. When it comes to the array of services and supports, even with the limits of government rates, the reality is that the public sector is committed to children with the most disabling conditions. I cannot say that's true for all the commercial carriers in Massachusetts. Of course on occasion, a child still has to fail up, we know that, because there aren't enough needs and resources out there. But the reality is that the public system provides the broader array of services, just not enough of them, yet. The public sector takes a systems approach, commercial insurance takes a procedure, in some cases, a diagnostic approach. The result is that the commercial system is fragmented, particularly when it comes to collateral services or coordination of care, as we like to think about it- case management, and the spectrum of services that we would expect a child should receive.

Even more troubling is when we think about what parity means. As Representative Balser and others would say, when we think about parity, and you know what I mean when I say parity right? That sort of commercial insurance coverage should match what we have on the physical healthcare side. When we think about parity, what we mean is mental health on the same terms and conditions as physical health. Well, there's a very interesting dialogue happening in the commercial insurance world right now. In response to the imminent implementation of parity at the Federal level, in meeting with insurers, a troubling theme kept coming up. The first time it came up I thought "Hmm, boy…" I'm just not really understanding that. The second time the theme came up, I went, "Hmm, two of them are now saying the same thing to me," and the third time when it came up I went, "Hmm, I smell a rat!"

So here's what it is: if you say you're now under the Parity Law, theoretically outpatient visits should not have a cap on them, it should be based upon medical necessity and utilization criteria. I said, so I don't understand how it is you can say that you're authorizing 8-10 without any authorization criteria, but then you're asking for either depending on the commercial insurer, the record, or implementing utilization management procedures. If I had a child and I went to my pediatric practice, somebody wouldn't say, well you can have 8 or 10 visits pre-authorized, but then if you want to come back the 11th time, you need to have a conversation with the insurance company. That just doesn't happen that way. So I was just the Commissioner for Mental Health, but apparently I was just not thinking about this correctly. I was told that mental health is *not* on the same par as physical health. Ah! A reframing of parity is to equate it not with physical health care, but as a specialty care, such as physical or occupational therapy- time limited, subject to referral, and medical necessity criteria and utilization review.

Now that's not what many of us envisioned when we thought about parity. So I do agree that as an employer, I have a responsibility. I have a lot of skin in this game because I think over the next couple of years- the message I want to leave with all of you, as we think about children's mental health, is that we will see the significant changes in Medicaid, and these are good changes, even though they're litigation driven, so they're a little rigid. There's a whole lot of things she said up there that I said, I was thinking there hm well as a provider Emily I'm not sure I would totally agree with all this. But it will create massive systems change, even though Rosie D., as Emily said, will never benefit from the services that were named for her.

However, the commercial side is the side where we will really need to engage to be enraged and engage with, because over the next year as we see Federal Parity implemented across the country and in the Commonwealth of Massachusetts, I believe we will absolutely see a reframing and narrowing in fact, of coverage, of commercial coverage for children with serious mental health disorders and for adults across the spectrum.

So with that we have a lot to do, I hope I have engaged all of you to be advocates. It is not so complicated, I am a clinical social worker by training, but you have a voice, you have a perspective, and as I always like to say, the Statehouse is our house, it’s the people’s house, and that is truly where good public policy can be made and I would hope you would all enlist your voices in that struggle. Thank you so much. [Applause]

Discussion

David Satin:

Thank you! What I've gotten from all of the speakers is that there is a huge need, that a lot of it is not being met, that there is a very complicated and disorganized and scattered set of resources. There are a lot of good intentions and good will. I'm impressed especially that Ms. Sudders started off by saying she's so optimistic that things are getting better, we're almost there. And then ended up saying: here's the terrible needs that we are struggling to get met against lots of opposition and and obstacles.

I guess to start off the discussion, I would like to ask: granted that some important things have gotten done, passing this legislation, getting this system of implementation going, applying this to a very difficult population in a specific agency, and engaging community advocates and community interest groups in this endeavor- Are we staying afloat in a very difficult lake of issues, or are we going in some direction that will make an understandable, measurable improvement? Are we changing something or are we going in some direction?

One of the issues that Health Care For All has raised, is one of the considerations is a public vs. private mental health system. Which are we doing? In defense of health care insurers, I would say they are doing what insurers do, what businesses do- they look for financial advantage. That's a business approach. If we as a society have decided to make a private approach to mental health services, and engage businesses in implementing that approach, why are we surprised that they act like businesses defending their own interests? And if you think that you can manage and drive businesses in a coordinated way, are you trying to herd cats? And trying to do what is unrealistic, is there another way that would work better, and will society accept that? So I guess, it's a lot of concerns about a very important situation. Are we going in a direction, are we going in a direction of some measure of success or are we paddling like mad to try to stay afloat and make a difference in one area but maybe not in the whole system. Is that is that a meaningful picture?

Mary Lou Sudders:

I think if you were to ask anyone who had an insurance card, that the role of insurance is to control cost and don't use it, I think we'd be shocked. And I think that truly is where medical insurance comes down. It should be in the business about that an insurance card should be able to provide you to the most appropriate treatment at the right time and at the right place, theoretically at the right cost. Having finished these conversations with all the insurers, they are very open about it. They are a business, and are about controlling cost. So I my thoughts on the commercial side is that as the public sector, as Medicaid makes changes and significant changes, I believe that we will see pressure on the commercial insurers to provide some of those changes. And we've seen that a little bit. Family stabilization treatment, which was a Medicaid provided service, some of the commercial insurers started to pay into it.

But I will leave you with my one cynical thought about commercialism and maybe I'm just being slightly too cynical about it. Is that when I was done with all the interviews I met this wonderful woman who's the head of public advocacy at Children's Hospital. So here are my two takeaways from all these conversations- one is if I had a child with a serious mental health condition who had commercial insurance, the first thing I'd do is get them off commercial insurance and onto Medicaid.

Panel member:

Mmm

Mary Lou Sudders:

I know- increasing the state cost!

Panel member:

No, I agree!

Mary Lou Sudders:

Or second is, if I had a child with a serious health condition with commercial insurance, my first call would be to a lawyer and then my second call would be to the commercial insurance. So let me just hand it over to Emily and some others, we really do want to hear what you have to think. I do think we have a bifurcated system, since we don't have a universal payer system, we have a bifurcated system, and unlike a lot of other things that happen in industries, when it comes to insurance the good news in Massachusetts is Medicaid and government with legislative oversight. We will see Medicaid significant changes, and hopefully we will see some pressure on the commercial insurers to sort of step up.

Emily Sherwood:

I just want to say a couple of things, I totally agree that as a matter of fact I want to tell people how to help get people on Medicaid, which is something called Common Health, which is for adults and children with disabilities. The important thing about this program is that there is no income limit. There is a sliding fee scale for premium. It's not cheap when you're higher income, but it can be a very important option for families with pretty significant ongoing conditions. So you should encourage families you work with, there's no harm in applying for Common Health. You get a letter, it tells you what your monthly premium's going to be, so it's an important option.

Just to say, moving in the right direction, we've in the past spent about $500 million a year on mental health and substance abusing services for the 1.3 million people we cover. We are adding $270 million to that total. That is a *significant* influx of resources. That is going to make a difference. So I think on the public side there's a lot to be very, very happy about. I think you know we don't have the commercial insurances single payer, we have a commercial system, we've got to control it with with laws like the Parity Law. Something just to note for people, as we implement universal coverage across the country, so there's a lot of stuff going on in medical care- more and more mental health care is going to be accessed through the medical system. We have to be very, very strong advocates for that being adequate and and sort of linking with our systems.

Ruth Balser:

Thank you, I think we'll all chip in on this. It's gonna be hard before 5:00 to hear from any of you, but I want to return to first of all thank you, Emily, for very complementary remarks you made about me and let me return the compliment about not only what a great policy advisor you were when I worked with you more closely, but your comments today about the cost of health care and the problems was really important. And I just want to underline, I think the cost of health care is the biggest problem we face right now in our country and our state, and I know I get calls now as a representative, more and more calls every day from people who can't afford the cost of their premiums and from small businesses in particular who can't afford.

Now in 2006, when we did Universal Health Care, we actually made the statement explicitly that we weren't going to deal with the issue of cost, we were going to deal with *access*. And, if I can tell a little story about the House side, also quality. Because what happened was there was an agreement on the part of Governor Romney at the time and the House and the Senate that we were going to tackle the problem of universal health care here in Massachusetts. We were not going to wait for the whole nation to do it, we were going to do it; state-by-state, we were going to lead. Governor Romney came out with the first plan and part of his plan, the way he was going to get universal health care coverage was he was going to create a lot of new crummy health care policies so that they would be cheap, and the way I knew they'd be crummy is that he had a language, a little sentence most people didn't notice, that said that we would create this- these new plans and those plans would *not* be subject to the state mandates, that over time the legislature had passed.

So that meant that mental health and substance abuse you know that we had worked so hard for was out, infertility treatments, all kinds of things that over time we had said a good insurance policy has to include he was he said had to go. The Senate came out with a bill that mirrored that language, and the House Committee version that first came out mirrored the same language. So I'll toot my own horn, I was watching for that language because I was kind of onto this issue, and I made a big issue of it in the House and said I wanted to file an amendment that would say that any new plans created would in fact have to be subject to our mandates. Luckily, it took about a half a second to convince her, your boss at the time. She was already there and she signed on. The speaker, in the face of me and your boss, immediately agreed. The House version adopted that amendment and then the Senate agreed in conference and at the end of the day, Mitt Romney signed it, who by the way went around the country taking responsibility for all these things he had actually vetoed.

But the point of the story is that in 2006 we were concerned about universal coverage, and we were concerned about quality of care. That's why we built in that kind of amendment. We said that if we cover everyone, we want it to be comprehensive. However, we kept making the mistake that we're not looking at cost. And that day is here now. The issue of cost is exploding, what you said that I thought was really one of the most important things said today is that, if we can't manage the cost of health care, everything will go out the window, and the problem is, how *do* you provide quality health care *and* manage the cost because it's so tempting to think that the way to manage the cost is to limit the quality and that's unacceptable.

Audience Member:

Well, you say managing the cost but has the cost even been defined or the program defined, in sort of the protocol. So that if you don't even know at the end what the cost is, how do you do that? How do you manage that?

Emily Sherwood:

I think people know a lot- I think you know in the field of health policy, people know a lot about cost. And you know so that you can look at things like you know hospital inquiry of infections and you know certain things, to to me it's it's more about the fundamental sort of drivers in our system, like where the financial incentives are alive with with providers you know so that's where our state our Secretary of Human Services and also nationally, people are really trying to figure out how to recalibrate the financial incentives in the system. But I mean, you know just read all the great people writing on this now, I think a lot is known, it's going to take a fundamental change to the system. And I think that's what we don't know how to do. How do you make big changes in an enormous enormously complicated system. But lots of smart people are trying to figure out.

Audience Member:

How're you doing? I'm Greg Matos, I'm a student here at MSPP and I'm thinking about the future of my career. I'm wondering if I have a voice and I want to put my voice behind something powerful, that fundamental change you're talking about, is it a single payer financing system here in Massachusetts?

Ruth Balser:

Well, I mean it's about politics. So, I've served for 6 terms in the legislature, and every term I sign my name onto the Single Payer Bill, and I'll keep signing my name onto it, but frankly, that's not the direction. There's no political will for that, frankly. And that's why we did what we in Massachusetts- we built a hybrid system. President Obama modeled it. I have to give credit to Senator Clinton, who campaigned on it, and then President Obama implemented it. And it's about politics, I mean at the end of the day you have to build a consensus.

Audience Member:

How do you persuade the people who created the reform in 2006 that it's not working? I mean how do you do that?

Emily Sherwood:

Well, you don't need to persuade. One thing I'll say, that's a hopeful sign. Is building a single system, even though it's a hybrid system. There still is this commitment to looking, governmentally, at all parts of the system in an integrated policy way, moves us towards the possibility of single payer. We're building institutions. Here's a Senator Kennedy who passed HIPAA, and we think of it as who you can give records to. It's kind of a stealth strategy, it's about beginning to have cross-platform policies that are universal throughout the system. So there's the potential, as we experience our health care system as one system because we now have universal avenues into it, it can prepare the ground for what the real issue is. Single payer doesn't make sense to people yet. And so it's got to be believable, you've got to see it reachable. That's something I just want to say like what made the bill happen and the big Health Care Bill happen. It's got to be attainable, and that was also what enabled the plaintiffs to do this lawsuit. There had to be a solution they'd fight for. Like it couldn't just be: do something. And that's where you guys come in. You're the articulate voice of saying: I know what works for my clients. This works, we've got sort of the technology on the shelf. Just do this and it will help my my patients in this way. That's where this expertise is really important to the policy development.

Audience Member:

I don’t now what the single payer system is. What does that mean?

Emily Sherwood:

It’s the example would be, that you have Medicare for everybody. So you pay taxes into a system and there’s one system, one insurance.

Audience Member:

Oh okay, so it’s like universal.

Panel members:

Universal- Canadian Universal. Yeah.

Marylou Sudders:

But like the Canadian system, so it’s like National Health Insurance.

Audience Member:

A couple comments. About Mass Health as a provider- I know that a lot of private practitioners do not want to take Mass Health because it is so difficult to get payments, the payments are not nearly as good in some cases, I wonder if you could speak to both of those questions without it taking another hour.

And one more comment, I mean the whole story about the CHINS. I have to say in my experience, I’ve never had that experience, but in terms of policy reform, getting services. I know that there’s always that horror story but I just want to put it out [inaudible].

Emily Sherwood:

Just quickly on the screening. [inaudible] is they wanted to make sure that these standardized screenings occurred in the schools. It was a problem for us as a Medicaid program because the lawsuit is obligating the Medicaid program to do things, not the schools, not DMH, not anybody else. The schools are not Medicaid providers, so the way we’re working with that is: we’re doing a lot of education at schools, to say to them, “You are often the first person outside a family to talk to a family about the mental health needs of a kid. We’re giving you options of what you can do now.” It’s a reasonable option to say, “Please talk to your pediatrician,” not like, “You need to get a psychiatrist,” so we’re really trying to do a lot of work at that.

The whole rate issue. I’ll just say one thing. People look at entitlement programs, whether it’s SPED, I also feel like I have a lot of understanding of what Special Ed programs go through, we’re sort of like sisters in the entitlement world. People think you have a ton of money. The reality is, because of trying to manage the budget, entitlement programs are under *absolutely* excruciating pressure from their political leadership to manage cost. So Medicaid directors, SPED directors in a given town, are under *tremendous* pressure from their superintendant or their governor. So it's been a historical thing, Medicaid rates are you know for [inaudible] section of the program, probably, I don't know that for a fact, have been lower than commercial rates. I think it's just something that you have to advocate, advocate, advocate on-

Audience Member:

[inaudible] As a school system person, we get more and more demand for mental health services, and we cannot say no because of cost.

Emily Sherwood:

Yeah.

Audience Member:

And you know that's not very consistent.

Emily Sherwood:

Yeah.

Audience Member:

Just to answer, something really nice about Mass Health. They pay at least twice as much for testing, for example, as does any private insurance company. They're incredibly generous, they've always been generous, they've never refused a request. They are reasonable, sophisticated clinically. At least in that area and working in a community mental health agency, there's nothing as gratifying as being able to having a conversation with a clinician. On very rare occasions, because they never say no, unless you say something stupid, which I've done. So they might call and say, really? But um never in my fifteen years in a huge public mental health agency have I been denied a testing request and we do very serious advocacy with our testing. And we work with Harvard lawyers.

Unknown Speaker:

Thank you very much.

Audience Member:

But I want to say, *double* what we *ever* get from any commercial company. As a community mental health, I know that individual providers ask for more money. So there is some kind of sophistication of the way Medicaid is meted- in the way Medicaid is meted out, I think Mass Health has been terrific.

Audience Member:

I'm a student here and I'm trained as a school psychologist and worked in the schools for ten years. I'm in the private sector on billing private insurances and it's funny because each time in the morning I would wear one hat under a school, and then I have to remember okay, in the school I can diagnose ADHD. So I can do certain things, but then in private practice, you know I have some other permissions, and I guess the thing that I'm really encouraging is, the school is a big part of a child's life, and we have to help our organizations work better because everyone is so frightened of budgets and constrictions...that it really makes it hard to advocate for the child. Because everyone's so worried about whose pocket the money going to come out of- so better communication, better lines, at least that's what I'm hoping to get out of this.

Audience Member:

I'd like to see the coordination really be advanced, because that is one of the biggest problems in child mental health, right now there's all these auxiliary services. And I've observed in the school districts the services are all tripping over one another, and you know one person doesn't know what the other person's doing, families are confused by all these different providers that are coming into their home or interceding in terms of the school. And if that's what you meant by things are going to fall out and get better, I hope it's going to happen because right now it seems like a colossal waste of money to me. When I watch all this stuff like you know flowing through here and nobody knows what anybody else is doing, and there's nobody coordinating it.

Emily Sherwood:

Well if the the kids who are enrolled in Intensive Care Coordination, there is a person who does do that, so it shouldn't be somebody who's in an intensive care position. And it's also the responsibility of the in-home therapy providers to play a role in care coordination. Something we hope to do when there's a little recovery in the budget is to work with outpatient providers, outpatient centers, to bring in more resources into outpatient to enhance *their* ability to do care coordination. But in the intensive care coordination, I mean I think I should talk to you offline about what these are exactly, because that is *not* what we've been hearing; it's certainly not what the care coordinator's funded to do, they're funded to have a coherent plans, that the family's bought into, and not have people tripping over each other, so I'd like to hear more.

David Satin:

One more question.

Audience Member:

It’s a a bit of a follow up on that question and wanting to hear more about the implementation fees, as a Vice President of an agency that oversees a number of programs in the public sector working with FST teams, doing CANS, ICC’s, CSA’s, seeing it all, and not seeing it work really well, and knowing that…

Emily Sherwood:

Can you just give headlines of what what your biggest concerns are?

Audience Member:

Children coming through the system and finding out they *have* a CSA or an ICC, and providers all throughout not knowing, and medications being lost along the line, kids not having the care. Frankly, a number of kids being removed from home and getting placed in programs and then when looking at it, they *have* FST, they *have* ICC, they *have* CSA. I think it speaks to quality. I think it speaks to: how are you going to from a large system ensure that- it is the programs have to be quality driven, empirically driven, but the gap between the theory and the academic part of it and the practice. Being a practitioner, I’m on the ground, in the trenches. It’s such a big gap!

Emily Sherwood:

Yeah I’d like to get more detail on that…I mean, it’s a huge implementation. We’re a year in, and the literature shows, it takes organizations about 3 years to get very good at doing wraparound. It’s very hard to do wraparound well.

Panel Member:

It’s *very* hard.

Emily Sherwood:

We’re collecting data. I think it’s very variable around the state. So I’d like to talk to you afterwards and hear where where you’re from and what what what what else you’re seeing.

David Satin:

I’m glad that the session has inspired so much interest and so many questions. Please continue the discussion after we end up, I want to let people go who have to. I’m glad that you attended the 33rd Annual Erich Lindemann Memorial Lecture and hope that you will be back to the 34th next Spring. Thank you and thank all of our participants. [applause]