

A WHITE PAPER

Assessing the State of Children's Mental Health Services and Family Support

Prepared by: Michael Kelsey, Steve Miccio and Trisch Luchnick

10/14/2010

With Input from parents, grandparents, teen-agers, siblings, sons and daughters, consumers and individual members from PEOPLE Inc., Astor Children and Families Services, the Dutchess County Office of Mental Hygiene, Dutchess County Mental Hygiene Board and Subcommittees, New York State Office of Mental Health, Mid-Hudson Chapter of NAMI, Cornell Cooperative Extension Parent and Family Educators, Mental Health America of Dutchess County, MidHudson Chapter of the National Association of University Women, Teen Challenge, Project Return and several elected officials.

Statement of Purpose

Five community forums were held throughout Dutchess County to obtain input from families and parents of children with mental health diagnoses, and then a sixth forum was held to hear directly from teenagers involved in the mental health system.

Through these discussions during the months of March, April and May 2010, we heard of many missed opportunities for quality treatment in a mental health system that encompasses many stakeholders from across the spectrum. The purpose of this document is to identify barriers and solutions/recommendations to improve the children's mental health care system.

Design

The forum design consisted of sharing information from two key documents concerning mental health:

- *Achieving the Promise: Transforming Mental Health Care in America, DHHS Pub.SMA-03-3831. Rockville, MD: 2003, and*
- *Infusing Recovery Based Principles into Mental Health Services*
<http://www.omh.state.ny.us/omhweb/statewideplan/2005/appendix4.htm>

While the documents were discussed, the audience shared their opinions and views on the current state of affairs in mental health services based on personal experience. The group was asked to develop a vision and share ideas that each person believed would help to improve the mental health system in Dutchess County.

The forum was designed to allow families and teen-agers to share and voice concerns on the system of care in a safe trusting environment. Some of the words and sentiment of this paper may appear harsh or critical, however it should be noted that these words reflect the perceptions and experience of family members and teen-agers in Dutchess County. The facilitators/authors want to make it clear that although there will be some critical language in the document, the end result of this paper is to offer solutions that the entire group agrees are imperative in transforming our local mental health system into one of measurable quality of care and treatment.,

Overview

“There are other things that can be done that don’t cost money.”

There are 62 counties in New York State and each county has a different mental health system. As one forum participant stated; “I recognize that Dutchess County has a better mental health system than elsewhere, but patients and families have very little opportunities to choose care. It is this, and this is what it is.”

An overriding principle was that improvement to children’s services should be based on the attitudinal will to change rather than an increase or shift in funding. “There is a perception,” observed one parent, “that money is so tied to this. Money should not be what drives needs. We need to get creative.” The ideas offered on the following pages – in the actual words or sentiments of consumers and caretakers where possible – represent a need for shifts in attitudes and behaviors by developing a system of care that is person-centered and recovery based. The idea that a child be tied to the mental health system for life is not and should not be acceptable practice. Many participants in the forums also agreed that there are low-budget recommendations that, if implemented, will result in better delivery of services to children and families. The central theme is one of recovery and hope, and that the outcome must be community and family-driven.

One overall sentiment that prevailed in the forums was that parents and families must be included as “part of the solution, not the problem” in implementing an improved approach to mental health care. Families feel their involvement is essential to the wellness of their loved ones as well as in fulfillment of their parental duties, “I want to make sure my son maintains his stability and wellness and is able to function,” spoke one mother, “I want to know what tools are given to him for now and in the future.” Parents said their kids need the support of families and they stated very clearly that many of the reactions to being diagnosed with an emotional disorder or mental illness is “I don’t want this.” The children and family members report not wanting to be ill in

the first place ... “they’re very angry.” Teens said the involvement of their families help them to cope with their illness and increase their rate and speed of recovery.

The stigma of mental illness remains the number one obstacle both in societal acceptance and among providers and practitioners. There is an observable tendency that rather than giving children the tools and confidences to succeed in life that instead we are preparing them for a lifetime of dependency on institutional services that does not necessarily benefit the child or society. “It goes to the heart of the stigma – the notion that the child will never be a productive member of society,” complained one parent. “There is a normal adulthood out there but the system does not promote it.” A re-channeling of outlooks on recovery to foster independence and self reliance is paramount.

“Education is probably the biggest obstacle and biggest opportunity” noted a participant. Schools are an untapped resource for fighting stigma through education on mental illness, for connecting families with the mental health system, for prevention, and intervention. Increasing the role and involvement of schools in the community of mental health system could and should result in the deepest impact in positively improving the social acceptance and delivery of services to young people and their families.

Issues & Recommendations

As suggested from the forums:

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Information Breakdown

NOT KNOWING WHERE TO GO FOR HELP

“The biggest problem is that parents don’t know where to go.”

“I begged people for years to tell us where we should go, how we find them (help)” voiced a parent about her inability to locate services in the community. It was a common theme voiced frequently at the forums. Parents said that often-times the services they needed existed in the community somewhere but finding them took enormous amounts of time and energy – things that parents of children during trying times have little of. “The struggle that exists within families is compounded by not knowing where to go” admitted one parent.

There needs to be improvements made in community marketing of services; better training and education offered to school personnel, clergy, librarians and others who have regular contact with families; one-stop shopping utilizing modern technology mediums like the Internet so parents can more easily identify pertinent community helps. There should be collaboration among service providers so that solicited staff is knowledgeable to refer parents to other health care professionals or community services offered at other agencies.

A parent complained, “I feel it’s like a part time job just to find the help we need ... We have to deal with all this research. I don’t have someone to work with to help find the answers. I’m constantly searching.”

It is noted that Dutchess County does have the Helpline service that is available 24 hours a day and parents reported that this is a very helpful and useful service. However, there was discussion on how the Helpline service can be improved to serve our community better.

FORUM COMMENTARY

“Even therapists and doctors don’t know enough of the support to help families and keep kids out of hospitals”

“School psychologists do not have lists of where help is available or options for help.”

“There are lots of services, but how do you get people to know of the services?”

“Have to improve access to what already exists. The resources are not being utilized, promoted or made widely known.”

RECOMMENDATIONS

A community-based **Education Committee** consisting of members of all pertinent disciplines such as Building Bridges¹ should be empowered with a larger role to create a county-wide Children’s Services strategic plan including:

- Implementing a mandatory annual training program for hospital dischargers, therapists in the health system, and others involved in the discharge process to learn what resources are available and current in the community. It was suggested that special attention be given to finance and entitlement services.
- Parent Teacher Associations should be educated on community assistance programs and services.

It is also recommended that a **Resource Subcommittee** be formed to address the task of creating usable resource guides that can be used in the public domain as was as other forms of reaching the general public, such as:

- Literature, bookmarks and other marketing devices should be made available at Parents Nights and school Open Houses, as well as other community events. “Libraries are a resource” to help stock mental health awareness books.
- “We need a “Helping Our Families Guide” on the Dutchess County. Gov website” – “a one-stop linkage on the website to all available services and groups.” “If we expand technology to reach parents at home, it’ll take care of the transportation problem.”
- A centralized county information center or website needs to be established and promoted so web-surfers can easily find what’s available via one portal. www.myydd.org is an example.

¹ Building Bridges is an ad hoc committee of the Children and Youth Subcommittee of the Dutchess County Mental Hygiene Board who are already developing bookmarks, helping families guides and reaching out to schools through their building liaison program. The County’s Children and Youth Subcommittee has found that schools want to be more involved and want to help. They have been reaching out to schools. They have established building liaisons to each school building and are holding forums at each school. They are talking mental health issues, improving communications and they are finding that teachers are receptive.

- HELP Line staff should also establish a web-presence where someone can instant-message them for help, or moderate a chat room or forum where questions on accessing resources can be answered by knowledgeable persons.

Information Breakdown

ALLEVIATING STIGMA

“Parents want understanding and not to have to apologize.”

“In 1978, schools were teaching that parents were the cause of mental illness,” remembered one participant at a forum. Today, while the cause of mental illness is still largely unknown researchers believe it is more a combination of biological, psychological and environmental factors. Yet the old stigmas survive– and word choices linger despite their dehumanizing effects – due to the misinformation in our communities. Parents feel victimized by a society that blames them and excludes them from treatment. Despite the FORUM COMMENTARY of mental illness and stigma in society there continues to be a lack of community education on the nature of mental illness and the possibilities of recovery. The lack of education is seen in the attitudes of school, health care and criminal justice professionals. Training should better prepare them otherwise. The community needs to develop an education program so that statements like this one heard at another forum become part of the past, “Nobody understands what mental illness is. With children people will say it’s due to parenting.”

FORUM COMMENTARY

“I had a principal tell me it was my fault.”

“We’re blaming the parents – a judge once stated, ‘See, if she had better parenting...’”

“They don’t understand mental illness. It’s a chemical balance in the brain, not that parents are not saying, ‘no.’”

“Nobody understands what mental illness is. With children people will say it’s due to parenting.

“Because I have an emotionally disturbed child, my family is now considered dysfunctional.”

“A school psychologist recommended ‘brain surgery’ to ‘fix our child.’”

“School districts tell parents ‘it’s a parenting issue.’ They are “punitive to parents.”

“There is no exposure to MH or behavior management in teacher training.”

“Lack of knowledge and understanding of what mental health is about.”

“Labels make you think you are crazy.”

RECOMMENDATIONS

The proposed countywide Children’s Services Strategic Plan (as well as the local government plan) should also address the stigma-alleviating recommendations:

- “Need to focus on massive education on anti-stigma.” “We need public service announcements and billboards” and “school kids doing plays and skits dealing with mental illness.” “We need success stories on what works and what does not work.” “We need to get the positive success stories out there. Along the same line – a positive message can be made about major contributions by Mentally Ill persons. We need to change the tone of the argument and take control of the argument. There are all sorts of prejudice out there.”
- Schools miss out on opportunities to combat stigma when they fail to treat Mental Health Awareness Month (May) on the same level as other congressionally designated months (Black History Month, Women’ History Month). School children in early grades could be taught about the emotional diversity and many contributions of successful persons who struggled with mental illness. The language and knowledge around recovery from mental illness should be a prevalent message during the month of May.
- “We need to educate teachers more. Need more people to go into the schools to talk about mental illness – not just high school, but elementary.” “Schools need to educate and treat the whole person. Mental health, educational needs, social needs, etc.”
- “Teach teachers what to look for... should go beyond teachers and include everyone involved in the child’s life: bus drivers, janitors, lunch ladies, receptionists, etc.”” School staff needs to be educated on mental illness and severe emotional distress. How to direct and support kids and families.”
- “The words we use – non-compliant, resistant, dysfunctional – our language needs to be more positive. It really makes a difference. I’d rather be multi-stressed, than dysfunctional. I’d rather be a person than a case, bed, or number” People first language should become the standard, i.e. person with schizophrenia or depression. Non-compliant should be viewed as a system failure rather than a person failure.
- “We need success stories to convince legislators and policymakers that some of what they are cutting is needed. Things like social activities.”

- “We need education in society – in the schools, work places, etc. we have to deal with people in all places. There’s fear out there.”

Information Breakdown

LACK OF INFORMED CONSENT

"I want to be a part of my child's choice."

Without adequate information, parents and users of mental health services are ill-equipped to make the choices best for them. These choices include selecting a good doctor or therapist, and choosing good insurance companies who will fund mental health services. It also means being consulted and included in mental and medical care treatment choices including what medications are safest, programs to participate in and whether alternatives to medication exist. Kids complain that they are not being told the most basic facts about medication in terms of side effects and why certain medications are chosen. Parents of school children cite a lack of assistance in making education decisions for their children. "We need advocates to help and advise us on IEP (Individualized Education Plans) plans. We need help to get our kids the good supports they need."

FORUM COMMENTARY

"Very rarely do psychologists go into details on side effects."

"I question doctors ... to tell me why. He says 'I am the expert.'"

"I want a choice in my kid's doctors and to sit on the treatment."

"Physicians don't like it when you question them."

"Patients lose when doctors hide behind HIPPA and do not share pertinent health information with caregivers. Families need to be included in the treatment."

"I did not learn until my son was dropping out of high school that he had a learning disability."

"If I don't agree to their (the school's) path I am a difficult parent and in a dysfunctional family."

Hospitals: "They slip in a new medicine sometimes but don't tell you."

"The outpatient services at St Francis – doctors mess around with your medicine. One medicine gives a rash, but they didn't tell me about it beforehand."

"Changing medication is done experimentally, not methodically."

“We need to educate the school system to work in concert with parents – how to enrich and encourage parents.”

“Insurance only seems to fund medication! Medication is needed sometimes, but many times it can cause even more problems! I need “alternative” methods, education, and therapy. You can’t be middle-class and afford good care for mental health!”

RECOMMENDATIONS

“I finally got a doctor who listened. Choice of doctors is important. I needed to know he would be there when I needed him.”

The proposed countywide Children’s Services Strategic Plan should consider:

- Increased training for parents was urged. Suggestions were made for offering ASIST (Applied Suicide Intervention Skills Training) and classes on Special Education IEP preparation for parents Advocacy Training for family members was also discussed.
- Parents should be encouraged to talk to pharmacists more about side effects and potential drawbacks or alternatives to medication.
- More information needs to be prepared and made available in doctor waiting rooms and other communal settings for alternatives to medication.
- Community outreach to families.
- Newsweek has 100 best colleges in U.S. – why can’t we have 100 best mental health services in U.S.?
- Families desire a rating system for doctors and therapists where recipients of services can evaluate and comment on the level of services similar to www.ratemyteacher.com or www.ratemyprofessor.com. Others suggested developing a “consumer report” on services in mental health system or on doctors or a 5-star system like with dining evaluations of restaurants. In rating programs, it was suggested that “it should be broken down into parts, for example: outcomes, information sharing, friendliness, involves family members, facilities, medical care, interesting activities during ‘down time.’” “Wouldn’t it be good to have a Zagat guide for mental health providers?”

- A Mental Health-friendly insurance guide was thought to be helpful with easy comparisons as to allowable hospitalization stays for mental health, medications, and therapy sessions, etc. “If a website is created, allow for a comment section of users – allow for a rating system.”

Breakdown of Care

SILOS

“Our system is very silo-driven.”

“When a relative was hospitalized in a different county, her medical records did not follow her and it was like starting all over.” There are many players involved in the community mental health system, but unless they communicate with each other care becomes fragmented, and can easily result in a lack of standards. Families said that hospitals need to communicate with doctors, doctors with therapists, school officials with community residences and families.

The free flow of information between participants in the community mental health system is further agitated by deficiencies in record-sharing and misplaced hospital/doctor reliance on HIPPA laws. One mother complained that, “My son’s doctor didn’t know he was in the hospital until two weeks later.”

FORUM COMMENTARY

“HIPPA laws prevent me from helping my hospitalized family member as hospital staff are afraid to discuss the case with me. I feel shut out of the treatment when she needs me the most.”

“Once he got his paperwork everything stopped. There was no engagement, no follow-through. Nothing was done after he walked out the door.”

“Hospitals do not communicate with local providers. They do not inter-mingle services as much as they should.”

“There is a lack of communication and continuation of care between counties, when hospitals are in one county and then returned to another.”

“My child went from St. Francis to BETA – and there was no connection.”

“I don’t know how they are considered community because they never talk to anyone.”

“It took me ten months, but I got my kid’s medical records from school and I was shocked by the lies in it. So many inconsistencies were in it. It is frustrating.”

“There is an education disconnect at community residences. Workers in the house try to get in touch with schools. There is no follow-through with the schools.”

“My loved one was released from the hospital to partial hospitalization, but nothing ever materialized and she end up back in the hospital.”

RECOMMENDATIONS

- Education of HIPAA among providers so that there is clarity and transparency about the law, so that the law is not used as a barrier to quality care.
- Development of shared Electronic Medical Records so that information to providing person-centered care can be delivered.
- Communication System development for out-of-town placement so that one’s return to the community is seamless.
- Doctors and providers should routinely provide patients with waivers to allow open communication.
- Mandatory staff training for hospital discharge coordinators to communicate and follow-up to make sure patients understand discharge plans. Family members and children should be included in the development of the discharge plan to allow greater success as a shared plan.
- Providers and schools need to be educated about health care proxies and honor them when presented by caregivers seeking information on patients.
- Providers need to ask patients about what other groups or physicians they are utilizing and employ a collaborative and transparent approach to care.

Breakdown of Care

Family Alienation

“The system discourages parent participation.”

“There’s a lot of fear in parents who are afraid to exercise their rights because of doctors threatening to call CPS (Child Protective Services).” Families want to be included in their relative’s care. With parents, this is of paramount concern. Caregivers want doctors to listen to their observations, involve them in treatment and train them to be able to provide care at home. Too often parents and family members say they feel excluded, ignored, or worse disrespected and blamed.

Parents want to be valued for their roles in the life of their loved one. With the decrease in local in-patient hospital services, children complain that long distance hospitalizations are making it difficult for families to visit, and hospital policies further wedge child patients from families. “Parents are seen as part of the problem, not the solution,” voiced one parent, “the culture needs to change. I know my child and I want to be a part.”

FORUM COMMENTARY

“Like the doctor I do not want my (parental) authority questioned.”

“I feel like I’m not being heard by doctors. I’m the expert on my child ... doctors have told me it’s my fault. You need to leave.”

I tell the doctor something and he then poo-poops (discredits) me because I don’t have his credentials. It’s so very frustrating.”

“I disagreed with a clinician and she threatened to call CPS to have my daughter removed if I didn’t do as she wanted.”

“I find that with a lot of us grandparents when we disagree or question doctors they ask, where is your degree?”

“One physician says I’m not in compliance with their instructions ... and since you’re not in compliance your granddaughter cannot see me”

“A psychologist once told a nurse, ‘keep her (the mother) away from him.’”

“Toughest choice of parents is to do what’s in the best interest of my child and sometimes it means he has to leave the county. ... It’s about how that child feels being removed from their community.”

“I feel like I know more than psychologists.

“Consumer movement has excluded my children and me.”

“Don’t look at me as uneducated, un-informed and don’t tell me I don’t know what to do. ... Don’t see my kid for two hours a month and then tell me I don’t know what to do. I’ve seen him all my life.”

“Help me as a parent to be a therapist; to be that therapist the other 28 days of the month. Tell me what I should be doing to help my child.”

Hospitals don’t want families to visit. If any child is hospitalized for mental illness, they don’t want us there – why? We’re seen as part of the problem.”

“I’d want to stay over with my child in the hospital. Beyond that a parent has to say goodbye at the reception center. You don’t even get to see the unit. I want to see where my child is staying. ... It’s not the same practice with physical illness.”

“In the hospital we barely get to see our family.”

“At Saint Francis, my parents would visit every day. At Rockland, it was every weekend.”

“I wouldn’t see my family the whole time I was there (in the hospital). It was too far for them to travel.”

“Educators have treated me as a dumb [woman], and if you fight you are labeled as a difficult parent and not a partner.”

“You get beat-up. If you don’t appreciate what you are given, you are considered non-compliant.”

“Can’t get into the county hospital if they are resistant of any services. They threaten parents, if you don’t hospitalize them.”

CPS (child protective services) second-guesses me for telling my daughter to take her medication. I had to fight them.

“Need to define ‘best interests of the child’ standard. CPS stands behind their interpretation of the standard whether families agree or not.”

“Families have to be seen as a valuable resource in taking medical histories. Families are never talked to. Teachers are never talked to.”

“At Saint Francis we didn’t get enough phone time. You got cut-off as soon as your time was up.”

RECOMMENDATIONS

County-wide Strategic Plan to address:

- Training for staff as well as families on trauma informed care.
- Families should be trained on how to deal in de-escalation techniques for the off-hours when doctors are not available.
- Training for parents in advocacy and intervention skills was suggested as a means for empowering parents. Desire was expressed for certification of parents to give them footing in discussions with professionals. “Certification would help me” one parent said.
- Hospitals/programs should include families as a rule. – Families should be made part of the treatment team. Policy should be written from the perspective of including families as part of the recovery goals.
- “Family engagement and parental peer support and adolescent peer support is critically needed in care facilities.”
- “CPS is seen as a punitive organization, and its staff should undergo sensitivity training.”
- Therapists should consider family therapy sessions more often.
- A Hospital Discharge Committee formed in the community can develop standards of care capable of delivering effective discharge plans and a monitoring system that can be implemented seamlessly.
- Family Mentoring System program development.
- Enhancement of In-home family education services.

Breakdown of Care

Inadequacies of Schools

“Schools are where a huge amount of the damage happens.”

“Kids are spending the day at school all day trying to be good and behave, such that no time is spent learning,” reported one parent frustrated that schools are not equipped to help children with emotional problems. Not only do faculty and staff lack the training to effectively relate to students with emotional or mental difficulties but certain practices commonly adopted by schools tend to do harm including use of seclusion and restraint, non-adherence to confidentiality, and inadequate training in intervention techniques. Upon hospitalization, instruction ceases as there are inadequate programs and safeguards in place to make sure kids’ education continues to the detriment of their later academic success. Parents vented frustrations with schools’ insensitivities to assist parents as partners and perceived tendencies of school personnel to dictate particular courses of action sometimes with threats of calling Child Protective Services. Drastic change was urged to combat the negative consequences schools were inadvertently having on kids. “School ruined his life,” admitted one parent, “It traumatized him, degraded him. Schools made him feel worthless.”

FORUM COMMENTARY

Inadequate to Educate

“There is no support, no follow-through, and no consistent systemic process for educating hospitalized children. School districts do not want to provide a dime and the schools turn a blind-eye towards seeing that hospitalized youth are receiving proper instruction.”

“Not enough schooling is done in hospitals. In Four Winds it’s just one hour, or 30 minutes – a very short period of time. At Rockland it’s just busy work. There was no instruction on the work. Teachers should do more. They won’t help you learn.”

“Schools are not individualizing programs to students. It’s still cookie-cutter and it cannot be. This creates failure. Failure in school setting leads into adult life: ‘I was not successful there, so I won’t be successful elsewhere.’”

“My son was given little support in school. They put him in the back of the room. ... He eventually dropped out.”

“It took my son five years in high school to graduate due to illness, not because he was stupid. The school work was useless. He wasn’t getting proper school work. The feedback was bad.”

“School is such a big source of stress for the child. Not getting from this environment what they need and schools refuse to recognize this.”

“They put so much pressure on her to be something she could never be, or do things she could not do.”

“The schools just considered him a bad kid; he’s not a bad kid.”

“Education system is too pre-occupied with the mandates they have to deal with, so that mental health is not even on their radar.”

“There are only two Education Advocates for all of Dutchess County. We need more education advocates. “

“Education is needed to teach people how to intervene.”

“OASIS School was a godsend. But it doesn’t exist for high school and looking at high school, I’m terrified.”

“Medication would impede his ability to learn so he would end in Special Education classes despite being a very intelligent child. My son would end up in Special Education classes not because he was dumb but because he couldn’t stay awake due to the medication.”

There is a lack of behavioral goals at BETA. “they never help you... you just have to do it by yourself.” Coping skills are not taught.

BETA: “It takes many hours to get to see a counselor, sometimes not even the same day.”

“We need to educate teachers more on what to look for in children – the very young and also high school children.”

“School work is lost for kids who are dealing with mental illness. It adds to the struggle and increases the disconnect from the community.”

“Hospital releases for kids correspond to school semesters as schools will not accept them until the start of a new semester.”

Inadequate Response

“If schools recommend it and you buck the system they will force you to get it or threaten CPS (Child Protective Services).” “They come off as punitive.”

“Once teachers printed up targets and put them on kid’s shirts. They made us feel like bad kids, when we were not.”

“When I go into crisis, teachers get in my face. They tell us to sit in the corner. I don’t like that they scream at you first.”

“Teacher’s shouldn’t be able to put hands on us kids.”

“Some teachers will throw you on the ground, and hit my pressure points.”

“Schools – they were hurting him. He was so miserable because he was so frustrated and angry at the schools. We couldn’t help him to tell the schools they were wrong. The school system was a nightmare.”

“At BETA, they don’t care if you pass or not, they just tell you to put your head-down.”

“The special bus took him away from all his friends and everything that made him feel normal and he ended up shutting down.”

“Schools are disenfranchising parents of their rights.”

“Schools are still allowed to restrain and seclude. My son has been in seclusion many many times. He’s also been held.”

“There is no regulation on kids and their ability to restrain or seclude a child.”

“A teacher put his elbow into my back, and another in my calf.”

“A kid with a bladder problem was not allowed to go to the bathroom and ended up peeing on himself.”

“Punishment is imposed on kids who cannot function under school’s time conditions.”

“BETA has a punch-wall room and a padded-wall quiet room. You could be in there for like an hour and a half.” There are six quiet rooms.

“Confidentiality is an issue in the schools. My son was pre-judged. Schools don’t operate under OMH (Office of Mental Health) guidelines.”

RECOMMENDATIONS

- Individualized Education Plans should address education for the hospitalized. Hospitals need to focus more attention on the education of young people while on the hospitals. There should be no transition needed from being an inpatient to returning to school the next day upon release.
- Parents need advocates to assist them in the development of Individualized Education Plans. Recruitment and training of education advocates needs to be a priority. There are many retired educators in the community that if asked would most likely be willing to comprise a volunteer corp. of Education Advocates.
- Schools in conjunction with parents need to develop and follow individualized education plans for at-risk students. This can help schools to build a relationship with the student and the family and allow all to understand and focus on what the student's home situation is like, what their illness is like, what their limitations and strengths are.
- Some schools have Special Education-PTAs. These may be worth exploring for parents of children involved in special education classes to make sure their needs are properly being met by the schools.
- Greater outreach of the mental health community to the schools is needed. Perhaps efforts reaching out to PTAs will also allow teachers and parents to identify at-risk children and pair-up with available services in the community prior to crisis levels.
- School is such a huge source of stress for kids. Stress relief classes would be helpful in teaching kids how to self-regulate stress.
- There is a need for increased emphasis on early screening in schools.
- Greater flexibility in teaching styles will permit more kids to learn and ultimately be successful. School districts should challenge and provide their faculty additional training to develop teaching skills. Parents report that some of the best teachers are those who bend the rules if it will keep a student academically alive and help him move onto the next level.

- School districts should rethink policies of seclusion and strive to provide the attention and help to Special Education children rather than first resorting to alternative schools or punitive actions.
- “At the ballot box people vote to cut special education, arts and music, sports – things that can help. ... the first ones to go in schools is health care. Nurses are gone, psychologists in schools are gone. One social worker for 400 kids in two different schools. As parents those are fights we need to fight at budget time. We gotta help kids in other areas than just math and science.”
- Develop peer support programs in the schools.

Breakdown of Care

Unavailability of Direct Care

“Too often there is ‘no place to go.’”

“My son should not go 90 miles away from those who love him. Why am I meant to feel bad for not wanting to send my child 90 miles away?” voiced a frustrated parent. Short-term hospitalization is not available in Dutchess County. No hospital beds exist. The closest available hospital beds require children to be separated from their families by great distances. Alternatives to hospitalization do not exist. There is a need for direct care services long before health deteriorates to the point of hospitalization. Detection and diagnoses takes too long and is often inaccurate, help is rarely available outside of normal business hours, and the shortage of child psychologists means there are long waiting lists and access to doctors is limited. Insurance company policies also serve as barriers to receiving direct care. Transportation also becomes a barrier to treatment and/or family involvement if the family cannot get to the child who is placed far from home.

The challenges families face in receiving mental health care would not be tolerated in other areas of medicine and yet it is so commonplace that even a six-month wait would be tolerable to some parents! “Children need faster service for mental health. To find a psychologist or therapist to diagnose, treat, and figure out can take years!,” wrote one parent, “Meanwhile kids struggle academically, lose self-esteem, families fall apart from the stress of dealing with children and peer interaction becomes poor. Can we get good solid help in at least six months?” (emphasis added).

FORUM COMMENTARY

“In order to get special ed. help for my child, he needs diagnoses from a child psychologist. You have to wait 3-6 months to get an appointment. You get there and take whatever diagnoses you can get (even if it is wrong!) just so your child can get help at school. Then your child can be stuck with a wrong diagnosis for a long time and then it becomes a confusing guessing game.

Nobody gets much help. But at least he got special education!”

“Shortage of psychologists especially child psychologists; many don’t want to take on adolescents due to risks of medication.” “Too few people are going into child psychology.”

“Out-of-county hospitals are not near public transportation, so families can’t visit.”

“If therapists go away on vacation there is no one who replaces them.”

“Meeting and support groups do not accommodate needs of the families: daycare and weekend timing. Daycare is a vital need as is transportation.”

“No local hospital exists.”

“He is not eligible for a community residence and there are no hospitals in Dutchess County, and to get the help he’d have to leave his community – his parents, doctors, and therapists so in order to get him help I would have to give up my rights. I won’t do this.”

“Make services available outside of Monday-through-Friday. My experiences as a parent was being told, ‘call your therapist on Monday or go to the hospital.’”

“What about that parent who doesn’t have a car or who works for minimum wage? Parents can’t access the system.”

“Insurance companies are regulating patients’ length of stay, medication or what program you are discharged to.”

“If there were activities that encouraged social interaction, it would prevent some of my brother’s depression. His biggest enemy is loneliness.”

“I am not sending him to go be 90 miles away – two hours each way. We have families struggling how to get there. These are real issues in real days.”

“There are no hospitals or facilities available to take in young people.”

“The whole ER only has three rooms dedicated to psych.”

RECOMMENDATIONS

- “Need to use capacity issues to drive change ... especially regarding youth hospital beds and apartment beds.”
- There is a need for individualized self-treatment wellness plans. With children now traveling long-distances for care and being treated by non-local clinicians who are unfamiliar with them or their case, a wellness plan “it would be great to have this plan follow a child to Rockland or Westchester.”
- “I think we need a warmline for children.”

- Hospitals need to facilitate video-conferencing so that out-of-county hospitalized children can see and speak with their parents and families when distance and the expense of travel keeps parents from visiting more often
- “We need access to providers in my community on evenings and weekends so we don’t have to always go to the ER.”
- State leaders need to be lobbied to raise the Medicaid reimbursement rate for psychiatric inpatient care so that such care can be profitable and hospitals boards will want to care for the community.
- “There must be alternatives available to sending people out of county for hospitalizations.” “There should be hospital diversion houses in every community.” “What if we convert an empty building at Hudson River Psychiatric Center into a community residence for youth?”
- “We tell doctors, we’ll forgive their debt if they work in rural areas. Let’s take the same mentality for psychologists to work in children’s psychology. Draw the people by giving them in return like debt-forgiveness for service – change the paradigm of how we get people to go into this field. They are needed. We have to find ways to bring people into the field so we can have more providers and increase hours serving people.”
- Development of non-urgent services with flexible hours beyond traditional 9-5 Mon–Fri.

Breakdown of Care

Quality of Care

“The mental health ward was so filthy, not painted, the furniture was dilapidated. It was so dismal and so disrespectful. Physically the environment reflected what people thought of mental illness.”

“Hospitals add more trauma” claimed one forum participant. There is the perception among the consumers and their families that the places that are designed for wellness to take place actually end up contributing more to the sickness than to wellness. From the physical environment and attitudes of staff, to admission, visitation and discharge policies the healing system is ripe for reform. The breakdown in quality of care is most apparent in the hospital setting, but also pertains to doctor-patient relationships and therapy sessions. The foundation of any relationship with psychologist or counselor must be premised on trust, and yet many forum participants found trust lacking. There is great need for all aspects of treatment to be unified towards wellness and the total recovery of the individual so that means match the expressed goal. “Hospitalization is so harsh,” expressed one parent, “It causes traumatic stress so that patient does not want to go back. It results in an avoidance of hospitals or a panic because of fear of the hospital. ”

FORUM COMMENTARY

“I couldn’t talk about how I feel today in therapy. I feel suicidal but if I talk about it, they’ll hospitalize me.”

“When my daughter was at St. Francis ... the mental health ward was so filthy, not painted, the furniture was dilapidated. It was so dismal and so disrespectful. Physically the environment reflected what people thought of mental illness.”

“Children’s mental unit is very depressing. Compare this to the Children’s cancer unit which is very hopeful – balloons, staff are cheerful, kid’s don’t feel then humans.”

“It was so depressing to be visiting. No one cared. No hope.”

“Hospitals have a very sick feeling environment that a child to goes into. The child walks saying I’m sick.”

“At Saint Francis you have to wait all day to get into a unit.”

“Lack of information from doctors and providers to patients on why and what the medicine does.”

“No one explains the diagnosis. That’s why no kids want to go to therapy – it’s not explained to them.”

“People should not have to wait hours and hours with children in the E.R. before they are evaluated – most times to be dismissed because the “crisis” is over. Families then have to go home and still do not have direction or support.”

“Children are put in with adults; There is no separation in the Saint Francis ER for medical triage before going to the Brinn Center. Parental access and peer support is prevented.”

“There is a lack of individual therapy for children, only group therapy at St. Francis.”

“My evaluation at Saint Francis was terrifying. I woke up in a strange place. I didn’t know where I was or what happened. They didn’t explain to me where I was or why I was there. They just gave me a needle and never really explained why I was there.”

“The system hasn’t been working. Children are being raised in community residences – some for seven years or longer.”

“Too many regulations creates paperwork so that professions spend too much time reporting and not enough on direct services. Bureaucracy makes it tough for therapists to do a good job.”

“At St. Francis, kids have to be medically cleared first. Parents have to wait outside the doors of the Brinn Center. In terms of being present for support it depends upon who is on duty whether they will let us in.”

“The HELPLINE only tells you to go to your doctor, go to the hospital or call the police. We need some kind of warmline to find what is available in the community, or to find someone to listen.”

“Help line is not helpful – they just tell you to go to the emergency room.”

“Saint Francis wouldn’t help me. They tried to tranquilize me when I went out of the room to talk to someone. They put me in a room by myself for three hours.”

Westchester Medical: “They require a doctors’ order to do everything: clip your toe nails, play video games, go outside. That’s not fair.”

“They wake you up at 3am to take showers and then you have to wait until 9am for breakfast. When I didn’t want to get out of bed, they flipped my bed upside down.”

“Funding sources have cutback therapy sessions from an hour to 45 minutes.”

“We do not have enough money for psychologists to spend more than 15 minutes.”

“The time we get is up so quick. I barely get to see her (doctor) – like once a month. I’m supposed to be seeing someone once a week.”

“Most psychologists see themselves only as disseminators of medication. ... We need to get professionals to buy into recovery and evidenced-based practices. ... Many people who committed suicide usually went to their primary physician 72 hours beforehand. The primary physicians need to ask patients about total wellness.”

“Need for hospitals to respect patients and communicate goals and methods. The system is dictated by insurance and crafted to move patients in and out.”

“I wish hospitals would do more than just drug you up. I wish they would help you resolve issues instead of just drugging you.”

“Hospitals are intimidating places for young people, and negative experiences of staff attitudes or memories of past conditions serve as barriers for receiving help in the future.”

“Parents are left out of their children’s treatment in hospitals ... We don’t know what happens there.”

“My son saw someone hang themselves in a hospital.”

“I know what can happen to a teen in the hospital ... I kept him out, but now because he was not in the hospital he cannot get into a residential place.”

“When insurance plans change there is a loss of continuation of care due to conflicts in plan coverage.”

“The nursing staff and security at Saint Francis ER was harsh to patients.”

“I’m afraid of them (therapists). I’m afraid to tell them my ideas because they might say you have to go to the hospital, and then I have to pay for it. They don’t listen. Hospitals are not always the answer.”

“Hospitals should follow the law on advanced directives. Parents should be educated on advanced directives. All patients should develop advanced directives.”

“Hospitalization can be avoided if there is greater access to services.”

“There are not a lot of child psychologists.”

“If you don’t want to explore medication you shouldn’t have to.”

“Poor discharge plans.”

“The way the model is set up is that the psychologist who does the prescription-writing really does not spend time with the patient, but relies on the second-hand knowledge of patients or therapists.”

“They don’t even want to deal with the child, they want to talk to me.”

“The children’s treatment plan is psycho-babble – my son has no clue what the terms mean.”

“Lack of information given to patients on diagnosis and treatment.”

“Hospitals claim they have no room and so won’t admit my daughter when she needs the care.”

“ER nurses are condescending to persons who come to them in need of psychiatric services.”

“Confidentiality is not respected in emergency rooms.”

“Confidentiality is a problem at hospitals.”

“The psychiatrists’ office was the hallway to discuss my case in front of everyone.”

“At the hospital I can hear staff talking about me.”

“Hospitals need to incorporate more time for activities – gym, yoga, art class, pool.”

“Hospitals need balance. Either they are under structured – like a playground that serves no purpose, or over structured – where you’re sent further into the system. They set you up for failure.”

RECOMMENDATIONS

“When a doctor will sit and listen to the opinions of my son, it makes a huge difference.”

- *“Psychiatric hospitals and rooms need to be bright, clean, hopeful places that promote recovery.”*
- *There needs to be a collaborative approach to individuals in treatment.*
- *“Early intervention is needed to help parents with meltdowns.”*
- *“We need to raise the bar on outcomes by evaluating hospitals, doctors, etc.”*
- *“Develop a ‘consumer report’ on services in mental health system or on doctors...or a 5-star system like with dining evaluations of restaurants.”*
 - *“In rating programs, it should be broken down into parts: for example: outcomes, -- friendliness, involves family members, facilities, medical care, interesting activities during ‘down time.’”*
- *“There needs to be a clearing house at hospitals – a community liaison — someone to talk to or be referred to an agency. Too many of us don’t know who to call.”*
- *“St. Francis Hospital needs to have a consumer-advisory board.”*
- *“Trust is needed in the system particularly in dealing with suicide-prone individuals.”*
- *“What about the idea of a ‘regular appointment’ versus a ‘long appointment’ – taken from the medical model – where time is built in so that as patient can opt for longer than a 15-minute appointment to ask questions or talk medication?”*
- *“Can a law be put in place so that psychologists have to meet with a patient for a set amount of time before prescribing the medication? They system seems economically-driven.”*
- *“Therapy needs to explain why you are there. Medication is not enough for any treatment. ... especially for a teen.”*

- “We need to discuss medications and alternatives so as to manage side effects more effectively.”
- “Hospitals should be required to provide written documentation that a person does not need hospitalization before turning them away.”
- “Need to keep kids out of the hospitals and in the communities.”
- “Need to take children into communities. Expose them to parks, libraries and other parts of the community, so that they see that they belong here. You can be a part of this.”
- “We need to support kids by telling them, ‘there is nothing wrong with you. This is who you are.’ It’s about managing who you are.”
- “Home-based systems is the light. It was the only time we felt we were part of the system, and not based on negativity.”
- “Home/community-based programs with work-linkage to natural community support are essential. Need the community supports for it to work.”
- “There is more out there for mental health than medication! Neuro-feedback, diet, allergy testing, supplements should all be presented to patients as options.”
- “Patients in the hospital should have access to their regular mental health providers while in the hospital.”
- “Early Screening is essential. Pre-testing helped my kids perform better than my oldest child who was not tested. If it hadn’t been for early intervention, I don’t know what would have happened?”
- “We need places for teens, kids and parents to do meet and do activities.”
- “We should have a crisis place for children -- a place to get him off the street, and engaged in social activities.”

Breakdown of Care

PROBLEM OF ELIGIBILITY

"I feel I can't get there because of money."

"Parents have to sign their kids away to get him the help he needs." Capacity issues and rigid requirements keep people from receiving the care they need for their loved ones. Our system needs to remove the barriers and the red tape that prevent those needing care from getting it. These barriers exist at all levels and serve merely to discriminate who gets care from those that don't. Treatment availability needs to be blind as to applicant while prerequisites relaxed so that access to care becomes the rule not the exception. "What he needs, I can't get him," confessed one parent, "because the system won't give it to him."

FORUM COMMENTARY

"I get into the problem of money and insurance won't cover it. You have to be very rich to get help."

"When my family needed a place to live when we lost our home, we were not eligible for housing as a family at that time of four – my husband, me, and my 2 boys. They only took single people."

"We had to have our daughter be homeless before she was eligible to good treatment."

"Criteria for programs is hospitalization. In order to access community residences one needs a prior hospitalization or WAIVER. Without a history of hospitalization the child will not qualify. The assumption is that there is not a severe enough diagnosis. Psychologists and therapist's recommendations are discounted."

"My son will be sent to a detention center because he needs a residence but I cannot get him there because he was not hospitalized."

"Community groups complain of capacity, but that's just a cop-out for not providing services. What is available goes to a small group of children."

“Waiting lists for residential facilities are prioritized to those kids needing it the most, but there is not a good test for judging the need. Past hospitalization is one of the criteria, but what about the kid whose parents kept him out of the hospital. How does he ever get space in a residential treatment center when it is needed?”

“My child is not eligible for VESID.”

“Once PINS go into play, your options are limited and they must leave their home community.”

“CPS has been involved several times and although there was no abuse, mental illness was a flag to stay and actually caused me to be denied custody of a grandchild based solely on a mental illness diagnosis.”

“To get him the help he needs I have to sign him over. How will he feel when I have to say you are no longer my son, you now belong to DSS? I had to do PINS and now I might have to sign him over to DSS. Our system forces us to relinquish our rights of our children to get them the help they need. ... what are my choices? ... I have to give up my rights to do what is best for him.”

RECOMMENDATIONS

- In-home medical care should be offered as an option besides hospitalization. In-home care is compassion-driven.
- “Treatment options need to be across all funding systems. Medicaid is allowing it but private insurance also has to allow it.”
- Eligibility criteria needs to be re-evaluated from the perspective of helping people in need rather than limiting help to only those who meet stringent eligibility requirements.

Breakdown of Care

LAPSE IN SERVICES BETWEEN CHILDREN AND ADULT SYSTEMS

“Parents of teen-agers are scared to death because their kids are approaching 18.”

“The difference between children and adult services is night and day. There is no transition.” The stress of raising a child with emotional or mental behaviors is exasperated according to parents by the existence of separate systems of care for adults and children. As a child turns age 18, the transition from one system to another is marked by chaos and confusion resulting in deficiencies in care. Complaints vary from poor preparation of children for the transition, gaps in service, eligibility requirements, and inattention to the life skills necessary for success and productivity in an adult world. Parents also fear their child’s 18th birthday because legal rights vest in the child and parents find the proverbial caregiver rug pulled out from underneath them. “My granddaughter became 18 and was doing very well, but when she turned 18 everything went downhill. Now she is struggling to survive. She became officially an adult so there is little opportunity for me to help.”

FORUM COMMENTARY

“If things were handled properly early and not given patchwork when my son was two-and-a-half, we wouldn’t have the problems now that he is 16 and on the brink of aging out.”

“My child was ‘cut loose’ and lost to her psychologists, therapists, crisis workers, etc. She lost everything once she got her IP diploma. ... she’s kinda in the middle. Nothing is working.”

“Dutchess County does not have but five youth beds in apartment beds. This is a very successful program. Dutchess County needs more housing beds for youth.”

“There are only five transitional housing beds for young people Dutchess County. Since in one of these beds, my daughter has made the dean’s list, holds a full-time job and is so successful all because people were willing to work with her at her pace. Without programs kids would have not have future. Where would she be without this program? We need to increase the amount of available beds.”

“Youth-trained professional don’t know the lingo to cross the divide between youth and adult systems. It’s difficult to make the transition.”

“We need to promote wellness during the transition period – cooking, drivers licensing, managing a check book, etc.”

“Kids are not being taught job skills, vocational opportunities or skills such as to live on their own one day” ... “education is also needed so that when he turns 18 a foundation is laid before he gets into the adult system.”

“We need more focus on transition plans for students leaving child MH system/school and entering adulthood/adult system.”

“Kids are aging out of facilities without good family contact. Need for planning.”

“Family Support is totally gone once someone turns 18.” “Unless he signs a waiver, I’m out of the loop.”

“My son has no wellness plan.”

“Staff are not prepared to prepare a child for adult transition. Staff anxieties are being passed onto children. More prep work is needed and long before they turn 18.”

“Providers and families are not informed about the adult mental health system which includes information about housing, treatment and finances.”

“What resources does my son – who is stable and doing good – get when he turns 18? Housing, jobs? Nobody can tell me?”

“Kids that are transitioning are really struggling.”

“Aging out is a big issue.”

“More needs to be done on the overall transition from children services to adult services. The age is fuzzy as there are some 18 year-olds who are not really ready in their maturity level. Some seem to be coming later on.”

RECOMMENDATIONS

“We need a passing of a baton from system to system.”

- We need schools to focus more on developing IEPs (individualized education plans) in conjunction with parents to help kids become gainfully employed later on and find their role in society so as to avoid dependency on services.

- There is a need for individualized self-treatment wellness plans for kids. Despite Office of Mental Health making a pilot law in the adult system there are no advanced directives in place in the children's system. Wellness plans will allow families and youth prepare for future events. The role that parents will have in a child's life after his/her 18th birthday needs to be carefully considered so that the appropriate legal documents and waivers are signed if the parent's role is to continue past the 18th birthday, or proper safety nets constructed so that no 18-year-old is left without support when he/she needs it.
- Training is needed for staff working in the youth system to prepare them to prepare children and families for the transition into the adult mental health system, as well as for independent living. Planning needs to start early so transitions are seamless.
- Non-academic classes in life skills through Dutchess County BOCES or at the Community College should be offered regularly.
- Employment programs and services need to start marketing teen-agers and preparing them for the workforce.
- Increased emphasis on social skills and activities that are not necessarily "medical" (clubs, field trips, recreation, vocational) will better prepare young people for the challenges of adulthood.

Breakdown of Care

RESPIRE

“The negative treatment of taking away my son causes traumatic stress to me as a parent.”

“Parents are losing their entire identity as the onslaught of a mental health conundrum consumes families and individuals.” This was a frequent plea of overwhelmed caregivers. Families are looking for coping outlets and respite services in efforts to rejuvenate and restore their strength and peace of mind. Parents expressed desires to stay with their children during hospitalizations, so that their children do not have to be divorced from them during their moments of need. “What about care-takers?” one forum participant asked, “We need supports so we can maintain ourselves to help them.”

RECOMMENDATIONS

- “Family Respite Weekends like Camp Getaway done in the Finger Lakes are needed locally. ‘It would be nice if we had something for mom or dad to get away, as a caregiver. Respite care for parents is sorely needed.”
- “Long term (days) or short term crisis respite needed in a comfortable setting where people can freely come and go.”
- “Peer support is so important.”
- “There needs to be more respite homes. Psychologists, doctors, etc. need to be more aware of these places and communicate their existence to parents.”
- “The Bronx has housing for grandparents to provide services for grandparents raising grandchildren. We could use these here.”
- “We need someone to partner with parents to help them find solutions, therapy, and recovery plan so it isn’t a full-time job for a parent.”
- “We need a Warmline for families.”

- “We need childcare for kids with special needs.”
- “We need more diversion, more respite, more WAIVER slots.”
- WAIVER slots need to be available to all and not restricted to recipients of Medicaid.
- “It is very important to have a family who doesn’t turn their back on you. Some kids have nothing to go back into once entered into a facility.”
- “There needs to be more support for siblings.”
- Development of safety plans suggested – a written out protocol for what to do when a crisis takes place.

Breakdown of Care

LACK OF PARITY

“There are at times where I wish my kid was mentally retarded because he would have better care.”

“If only we could treat mental illness the way we treated physical illness,” wondered aloud a parent, “somehow we make it more mysterious.” Seeking justice and equity, families could not help but compare the differences between mental health treatment and that of physical care, or even that of the developmentally disabled communities. Disparities in hospital protocols, priorities or seemingly better services including those that are cradle-to-grave add insult to injury to those struggling to acquire care for psychiatrically-struggling relatives amid a fragmented and fractured system. Greater distribution of services in a fair and equitable manner is desired. “One of the challenges my son faces is developing friends. He is ostracized and left out. We don’t do a lot to build social skills or cures including daycare or after-school activities. This is a large gap. If my child was mentally retarded I would have these services.”

FORUM COMMENTARY

“OMRDD (Office of Mental Retardation and Developmental Disabilities) – is much better service than OMH (Office of Mental Health), since it’s cradle to grave.”

“When my son who has ADD started using pot, no one cared. He had to go to harder drugs before I could get him any help.”

“We talk about diabetes and cancer – it’s the same thing.”

“Hospital beds and children’s wards are available for physical ailments, but not for mental health needs.”

“People are complex and do not fit neatly into our molds.”

“Healthy NY does not cover prescriptions for mental health medication.”

RECOMMENDATIONS

- Policy makers in government, hospital administration and community need to be educated and lobbied on the prevalence of mental health needs in the community and not allowed to shortchange it in law, funding, state insurance programs, or Medicare reimbursement rates. An equal concern for all in society is needed.

Conclusion

“We need the grassroots to increase awareness and put pressure on Albany to not overlook these issues.”

The greatest mental health challenge facing Dutchess County is the absence in the county of a mental health facility to treat children in crisis. The community must find a way to increase space, treatment and expand eligibility so that children can be treated in their own communities, with family and local practitioners accessible.

A community education campaign can change attitudes and alleviate the stigma surrounding mental illness. A community that’s educated on mental illness will anticipate the needs rather than just react to crisis. Success stories, emphasis on positive recovery outcomes, and amplification of major contributions by mentally ill persons are powerful and deserve greater attention.

For the most part there are adequate resources to serve those in the community, but these services need to be better promoted and silos eliminated. The schools have the kids and often are able to identify problems but lack the information to link those needing services with the help they need. Our system needs to keep reaching out to the schools, develop individualized education plans, and incorporate the school communities into the system. Linkage with schools is our greatest prospect for positive change.

Shifts in staff attitudes, informed consent and recovery-focused environments will definitely improve the quality of care. There is no substitute for person-centered care close to home and easily accessible.

The system tends to self-perpetuate, trapping people in its ranks. The best and semi-untapped way to end this self-perpetuation is to involve and increase family support. Families need to be embraced as partners. Additionally teaching life skills and bridging the gap that exists in transitioning from adolescents to adulthood requires steadfast focus. “Just because you have a mental illness, does not mean you have no future.”

Our current model of care “needs to be tweaked so that consumers can see a rainbow and know that you’re going to get better.” Particularly when working with children we cannot doom them to a life of dependency within the system, but must give them the skills, education and optimism to lead normal lives. A countywide Children’s Services Strategic Plan encompassing these goals is the best means to turn our vision into reality.

“There is hope.”



Vision

WE ENVISION A SYSTEM WHERE:

⌘ ACCESS TO CARE is immediately available, 24/7, wellness-focused, trauma-infused, person-centered, local, seamless, outcome-driven, with appropriate daycare offered and linked to the natural supports of the community.

⌘ EMERGENCY ACUTE CARE and COMMUNITY RESIDENCES are local, reputable, family-inclusive, wellness-focused, person-centered, safe, with sufficient space, expanded eligibility, trauma-informed care, standards or care adherence in function, education, treatment and outcomes, and with time-limited yet efficient length of stays, with advocacy at every level, where advanced directives are taught and respected and where healing and recovery can take place amid a positive and optimistic atmosphere.

⌘ INEQUITIES IN TREATMENT are abolished, parity the norm, treatment is value-based, standards of care is practiced, where services exceed capacity and where eligibility to mental health treatment is universal.

⌘ TRANSITIONING is from children to adult systems is seamless, partnered, guided, effective, collaborative and centered on all aspects of a person's wellness needs including education, employment, housing, socialization and life skills training.

⌘ PLANNING is central to the mental health system of collaborative design complete with a hospital at the center of sufficient capacity, with ample programs meeting the needs of early intervention, special education, vocation training, transitioning, crisis diversion and individualized wellness plans for all consumers so that the continuum of care is both efficient and effective.

Vision (continued)

WE ENVISION A SYSTEM WHERE:

⌘ FAMILY EMPOWERMENT is the norm not the exception, where parents and families are made partners in the decision-making and given the education and training to best serve their loved ones.

⌘ COMMUNITY EDUCATION is comprehensive, easily accessible, wellness-focused, technologically available and continuously provided to health and social care workers so that families once identified are supplied with immediate orientation for one-stop shopping for complete linkage to community resources, at-risk individuals are detected early, those in the system are advised of their rights, and the larger community is made aware of available community help, success stories and greater acceptance of the mentally ill.

⌘ SCHOOLS design curriculums to teach kids about mental illness, suicide prevention and abolish stigma, train their teachers in prevention and intervention, foster suicide prevention programs, collaborate with the larger community, utilize the school network for furtherance of community education and link families in need with community resources.

⌘ RESPITE/DIVERSION opportunities are valued, promoted, widespread, immediately accessible, providing appropriate levels of care for children, adults, families, co-occurring and clinical components without waiting lists so that crises are diverted and used as opportunities for learning new wellness tools and recovery.

“Be of good cheer. Do not think of today's failures, but of the success that may come tomorrow. You have set yourselves a difficult task, but you will succeed if you persevere; and you will find a joy in overcoming obstacles. Remember, no effort that we make to attain something beautiful is ever lost.”

- Helen Keller