

Fighting for (E)Quality: An Examination of Mental Health Care for Underserved  
Children in New York City



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## **Executive Summary**

## **Executive Summary**

Although there are more children who suffer from psychiatric disorders than from autism, leukemia, diabetes, and AIDS combined, only twenty percent of emotionally disturbed youth receive treatment. Youth living in poverty are at even greater risk of developing a mental disorder, but are less likely to receive care compared to their more affluent counterparts. Children living in these circumstances are invisible in society and must be given an equal opportunity at a high quality of life. As a result, we must address this issue and change the structure which restricts underserved youth from receiving mental health care.

The Affordable Care Act (ACA) is a new, key policy reforming healthcare. Congress proposes that the ACA will bring equitable, comprehensive, and coordinated healthcare to all populations by expanding access to public and private health insurance. ACA is also designed to bring a more desirable quality of healthcare by provisioning coordinated, comprehensive, and effective treatment, along with expanding Medicaid eligibility. The ACA is expected to improve the mental health care system for underserved New York City youth.

This research is an examination of the Affordable Care Act and its impact on children's mental health care in New York. In order to determine the effect the ACA would have on children's mental health care and potential policy changes to create an equitable system, I examined the ACA and interviewed several mental health care providers and policymakers.

I found that due to the novelty of the ACA, no clear evidence is available to determine the future impact the ACA would have on children's mental health care. Although some experts remain hopeful and optimistic for great results, they point out that the mental health care system was very inefficient, isolated, and culturally incomprehensive. Unfortunately, the ACA might perpetuate the same prior issues in the system. Additionally, some professionals suggested that children's mental health care is changing in two ways. One is transitioning Medicaid covered youth to Medicaid managed care in order to contain costs. The other change to the system is covering the newly Medicaid-eligible children through Child Health Plus, which divides families and healthcare coverage.

Based on my research, I recommend several policy changes in order to increase access to mental health care for underserved youth. First, the local government must educate parents and providers about the ACA and the structures of its implementation. Next the government should also consider opening Medicaid coverage to undocumented children, stipend child psychiatrists, building more school-based mental health centers, and restructuring the system. These suggestions are resolutions to the issues New York City's underserved children must face.

Finally, I conclude by stating more, continuous research on this topic must be conducted in a few years. Because the ACA is new, determining its future implementation remains challenging at this premature stage of its existence. Therefore, evaluating its operations and structure within a few years will allow a measurable investigation of this subject.



## **Introduction**

## Introduction

About 4 million children<sup>1</sup> and adolescents<sup>2</sup> suffer from mental illnesses. Of the twenty-one percent of children and adolescents who have a mental illness, approximately seventy percent do not receive the treatment and care that they need<sup>1</sup>. Although there are more children who suffer from psychiatric disorders than from autism, leukemia, diabetes, and AIDS combined, only twenty percent of emotionally disturbed youth receive treatment<sup>3</sup>. One of the most vulnerable populations in the United States is children and adolescents. Rates of mental illness among homeless youth range from nineteen to fifty percent<sup>1</sup>. Mental disorders disproportionately affect children living in low-income communities, usually placing them in juvenile detention centers, due to the lack of treatment services in these neighborhoods. Emotional disturbance is also associated with the highest school dropout among all disability groups – only thirty percent graduate with a standard high school diploma<sup>3</sup>. A poor, minor of color with a mental illness is more likely to experience a low quality of life and a systematic perpetuation of the circular trend that keeps low-income people in poverty. This condition results in the lack of health care, especially mental health care.

Over 15 million children live in households with incomes below the federal poverty line and 31 million children live in low-income households<sup>4</sup>. In 2012, children represented twenty-four percent of the total population and thirty-five percent of people

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<sup>1</sup> Schwarz, Susan Wile. *Adolescent Mental Health in the United States*. New York, NY: National Center for Children in Poverty, 2009.

<sup>2</sup> NAMI. *Facts on Children's Mental Health in America*. Report. National Alliance on Mental Illness, 2010.

<sup>3</sup> Office of Mental Health. *The Children's Plan: Improving the Social and Emotional Well Being of New York's Children and Their Families*. Report. New York State Office of Mental Health, 2008.

<sup>4</sup> Wight, Vanessa R., Michelle Chau, and Yumiko Aratani. *Who Are America's Poor Children?: The Official Story*. New York, N.Y.: National Center for Children in Poverty, 2010.

in poverty<sup>5</sup>. This phenomenon is caused by a multitude of components including lack of education, limited job access, race and ethnicity, and overall systematic classism. Low-income communities lack a great number of public services. Living in low-income communities poses greater risks to children's health, committing crime, and failing school. The probability of being and staying poor is also higher for those who are primarily raised in poverty, as well as being dependent on race and ethnicity, or whether the parent(s) and/or guardian(s) are immigrants, and if the child is in foster care<sup>4</sup>. Particularly, children of color are disproportionately poor<sup>4</sup>, which reflects the United States population where people of color are disproportionately poor<sup>2</sup>.

Clearly, there is a vast disparity between the unmet need of children who require mental health services and those who receive them. These statistics show that race and class has a strong effect on health care. Segregation evolves from structural racism and classism which adversely affects the health of poor communities of color, both directly and indirectly<sup>6</sup>. To a further extent, ableism intersects with race and class, creating a wider gap in mental health care of underserved children. Children living in these circumstances are particularly vulnerable to being invisible. As a result, we must address this issue and challenge social structures that restrict underserved youth from receiving mental health care.

The Affordable Care Act (ACA) is a key policy Congress proposes that will bring equitable, comprehensive, and coordinated healthcare to all populations. The ACA is

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<sup>5</sup> United States of America. Census Bureau. *US Census Data*. Accessed October 2013. <http://www.census.gov>.

<sup>6</sup> Smedley, Brian, Michael Jeffries, Larry Adelman, and Jean Cheng. "Race, Racial Inequality, and Health Inequities: Separating Myth from Fact." *Unnatural Causes*.

proposes to expand access to public and private health insurance while seeking to change the way health care is provided and paid for across the United States<sup>7</sup>. Through several provisions, the ACA will expand and improve health care services for low-income and uninsured Americans, estimated to cover approximately 5 million uninsured children and adolescents<sup>7</sup>. It is predicted that once the ACA is implemented, it will resolve many of the issues faced by underserved children by offering Medicaid to a wider population. Thus, it creates more entry points into the mental health system and may improve quality delivery of services to underserved youth.

## **Purpose**

Furthermore, children with mental illness already face difficulties with their academic, social, emotional, and, at times, physical lives; children living in poverty with mental illness have a lower quality of life than their more affluent counterparts. Having a mental illness makes normal functioning difficult, and dealing with a mental illness while living in poverty makes normal functioning nearly impossible. There is a lack of equity in the health care system. Thus, it is important to incorporate equity into the Affordable Care Act as well as the mental health services the ACA provides for disadvantaged children. Mental health care must improve drastically, especially for those most at risk: poor children of color. Through my research I will attempt to disassemble the current stigma and climate that is present around mental health disorders which inhibits effective treatment. This research serves to investigate mental health care in conjunction with poverty from a new and innovative approach of both top-down and bottom-up

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<sup>7</sup> Dutton, Melinda and Alice Lam. "Implementing National Health Reform in California: Opportunities for Improved Access to Care." *California Healthcare Foundation*. (March 2011).

perspectives. This project will examine the impact the ACA has on children's mental health care in New York City. New York made the second largest cuts, after California, to their states' mental health budgets and both states hold the two largest public school districts in the country, New York City and Los Angeles, respectively. In essence, these state policies should affect a great number of children in the United States. Furthermore, I will recommend policies in order to aid children in low-income and communities of color to easily obtain effective treatment for their mental illnesses.

### **Research Question and Sub-questions**

Thus, in my effort to examine the effect the ACA will have on underserved children's mental health care I have a research question that addresses two components of this policy. Once implemented, on January 1, 2014, how will the Affordable Care Act affect children's mental health care for underserved children? Furthermore, what policy changes should be made to in order to make the mental health care system more equitable for underserved children through the ACA?

This document will illustrate the history of mental health care and connect how ableism has integrated itself in US policy and the healthcare system. It will also describe how racism and classism interact with ableism which restricts access to mental health care by underserved children. Then, I will present my methodology and analyze findings. Recommendations of policy changes to the ACA will follow and then draw conclusions based on my research.

### **Personal Interest**

I first became interested in children's mental health care when I began interning at Pacific Clinics last semester. Pacific Clinics is a day treatment center that provides mental health services to troubled youth who are insured through MediCal. Being a Psychology and Urban & Environmental Policy double major, I felt that this is a great model which naturally intertwines aspects from both departments. With the ACA being a new policy involving health insurance expansion and, ideally, increased access to mental health care, I thought this would be the best opportunity to unite my knowledge of psychology and urban policy. My interest in social justice also provoked me to focus on low-income neighborhoods and communities of color because people living in these areas are disproportionately underserved.

This pattern of limited healthcare in communities of color has been a prevalent issue for years. In the 70's, the Black Panther Party recognized this large disparity in healthcare, and included it in their ten-point plan. The Black Panther Party initially identified how racism affected healthcare and stated that insurance does not mean good health care or receiving any treatment at all. This organization sparked conversations discussing the interaction of race and poverty and challenged inequalities which the black community faced in healthcare. We can see that not much has changed since this time period and in some ways the situation has deteriorated. Though the Black Panther Party focused on medical healthcare by building medical clinics throughout the US in black neighborhoods, parallels can be drawn between mental and medical health care to show the gaps in treatment. These issues faced by blacks are largely due to institutional racism, primarily focusing around a lack of access to basic needs and opportunities that

subsequently affect the quality of life. To a further extent, racism and sexism have played an even stronger role in the healthcare of black women.

For centuries, black women have paradoxically been invisible and silenced in society, while simultaneously being eroticized and exploited. The most prominent representation of black women are hypersexualized, objectified, and dissociated from whiteness<sup>8</sup>. Deviant sexuality is often presented with black women, usually dismembering them in a figurative manner, into parts rather than view them as whole person. They become something that is on display to look at, rather than being interpreted as a whole human being. Since the beginning of slavery and black women's presence in the United States, they have had no rights or control over their bodies which has been perpetuated through a continual racist and sexist social structure. During slavery, black women were commodities who were available to anyone white. From this system the sexuality of black women developed as deviant, deriving from their rapes by slave owners. This intersection of racist and sexist sentiment has been sustained in varying social structures such as housing, employment, and health. Due to racism within the healthcare system there is a particular vulnerability to black women's bodies. Forced sterilization, highest percentage of HIV/AIDS rates, and high rates of infant mortality are a few examples of the mistreatment of black women, their sex, and health.

In addition to issues regarding black women, I have also always had a profound desire to help others, especially children. Since high school I have volunteered and worked for different programs and facilities which specialized in the education and

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<sup>8</sup> hooks, bell. "Selling Hot Pussy." In *Writing on the Body: Female Embodiment and Feminist Theory*, by Katie Conboy, Nadia Medina, and Sarah Stanbury, 122-32. New York: Columbia University Press, 1997.

supportive development for children. As a Psychology and Urban & Environmental Policy double major this topic matters a great deal to me. I first and foremost believe in equality for all and am very passionate about working to solve social justice issues, especially those faced by the most vulnerable population: children. Another interest of mine is psychology. I am fascinated about the different aspects that contribute to a person's social, emotional, and overall psychological development. Incorporating the two fields was not very difficult because of my interests. Although I have not previously studied health care, I believe it is one of the many areas in which a comprehensive and equitable policy would have an immediate positive outcome on mental illness.

In general, mental health care is important because over 70 million people in the United States will develop a mental disorder at some point in their lifetime. When raised in poor and inadequate living situations, children are especially vulnerable to developing mental illness. Children living in low-income communities confront social inequalities and face incredibly difficult hardships daily. Through no fault of their own mentally ill children have high risks of being criminalized, low school performance, poor physical health, and experience homelessness as well. Like all people, they deserve to have a high quality of life. Interning at Pacific Clinics has shown me how important mental health care is and the significance in treating low-income children with mental disorders. Essentially, an equally accessible and culturally comprehensive children's mental health care system can prevent and effectively treat childhood pathology.

Finally, to answer the question: "why am I interested in this research?" I am interested because this research holds a deeper connection to black women's history of oppression and the role racism and sexism has played in a past of controlling our bodies.

This past has evolved through several movements connecting to the Black Panthers and Black Feminism which challenges the intersectionality that racism, sexism, and classism plays in the healthcare system. Because of this and my current internship at Pacific Clinics, I thought that addressing an issue that disproportionately affects children of color regarding a new policy would be a good model for my comprehensive senior research project.

## **Setting the Stage**

### ***What is the ACA?***

On March 23, 2010, President Obama signed a healthcare reform, the Patient Protection and Affordable Care Act (PPACA), into law<sup>9</sup>. The PPACA and subsequent amendments, collectively referred to as the Affordable Care Act (ACA), is a new healthcare reform policy in which its provisions outline an establishment of integrated and comprehensive healthcare system and services through expansion of access to public and private health insurance<sup>7</sup>. The ACA has ten titles that focus on reforming the healthcare system. Provisions to the ACA primarily address medical health insurance, although there are a few specific areas that involve children's mental health care. With the implementation of the ACA beginning January 1, 2014, many anticipate that it will open access to a large portion of underserved children to mental health care. Additionally, it is predicted to provide quality, coordinated, and culturally comprehensive care to children living in low-income communities.

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<sup>9</sup> Cunningham, Jennifer, Lindsey O'Brennan-Grimm, Nicole E. Brandt, Nancy Lever, and Sharon Stephan. *Health Care Reform: What School Mental Health Professionals Need to Know*. Report. Baltimore: Center for School Mental Health, 2012.

### ***Who are underserved children?***

The children that will be most impacted by the implementation of the ACA through expansion of health insurance are the underserved youth. More specifically, the underserved population consists of children, who are uninsured, living in low-income communities, covered through Medicaid, in foster care, in the juvenile justice system, and have been removed from the home for various reasons. Of this underserved population, children who have mental disorders that are diagnosable using the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V) are the youth I am specifically addressing when using the term “underserved children.” For instance, youth who have mental retardations, other limited mental capabilities, or physical disabilities are not considered a part of this analysis on mental health care. Rather, children and adolescents who have severe emotional disturbances and/or behavioral health problems that are diagnosable in the DSM-V are the underserved population in which my focus is directed. These children are particularly vulnerable because there are very minimal resources for them to receive proper treatment when uninsured or in low-income neighborhoods.

### ***New York City as a Model***

New York City has the largest public school district, serving about 1.1 million children<sup>10</sup>. Of this student population, over eighty-five percent are children of color. Additionally, children make up twenty-five percent of poverty in New York City, while eighty-three percent are of color<sup>10</sup>. Furthermore, nearly 2.6 million New Yorkers are

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<sup>10</sup> The Official Website of the City of New York. Accessed October 2013. <http://www.nyc.gov/>.

uninsured<sup>11</sup>. In comparison to other states, New York has an average quality mental health care system. With the proper policies, it has potential to be one of the best states for mental health care and serve thousands of people. In essence, I expect that if New York City has the largest public school system with the majority of students being of color, then it serves as a good model for assessing the ACA's impact on children's mental health care. Also, California and Los Angeles are included due to its similar local and state governmental structures to New York. Los Angeles has the second largest public school district, serving approximately 677,538 students who are mostly children of color as well<sup>12</sup>. Due to their similar mental health system structure and size of public school systems, the ACA would, in essence, be affecting the largest number of children in these two cities. Los Angeles serves as a secondary model to evaluate the ACA and implement policy changes to make it equitable for all children.

### **A Brief History of Mental Health Care**

The history of mental health care in the United States is a sad one, filled with discrimination, dehumanization, and inequality. Beginning from a time when people knew little about biology and defects of the brain, mental illness has been highly stigmatized. Due to the general public's misunderstanding of psychological disorders, those who suffered from mental illness were mistreated<sup>13</sup>. At different periods in history, explanations for the cause of mental disorders have changed from supernatural and religious to biological and psychological. Many early philosophers, physicians, and

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<sup>11</sup> Wooldridge, Judith. *Implementing the ACA in New York State: One Statewide Foundation's Approach to Preparing for 2014*. Report. New York: New York State Health Foundation, 2013.

<sup>12</sup> Los Angeles Unified School District. Accessed October 2013. <http://home.lausd.net/>.

<sup>13</sup> Kring, Ann M., Sheri Johnson, Gerald C. Davison, and John M. Neale. *Abnormal Psychology*. 9th ed. New York: John Wiley and Sons, 2009.

theologians believed that disturbed behavior reflected the displeasure of gods, witchcraft, or bodily possession by demons<sup>13</sup>. Treatment for people with mental disorders during this era consisted of exorcism, prayer, and more extreme responses, such as starvation.

Once medicine was separated from religion, magic, and superstition, doctors began to classify mental disorders as illnesses of the brain. However, treatment for this new biological approach to mental disorders was still very harmful and dangerous to patients. Some of these practices included bleeding, forcibly holding mentally ill patients in hospitals, and, much later, performing lobotomies<sup>13</sup>. Mental asylums resembled prisons because patients were not permitted to leave until cured, sometimes chained to the walls and beds, they were locked in holding cells as rooms. Patients with mental illness were treated as beasts and some hospitals served as zoos for the open public to visit and gaze at the imprisonment of the mentally ill<sup>13</sup>. However, soon there began to be movements of mental health care which developed into basic human rights activism to create parity. Philippe Pinel and Jean-Baptiste Pussin were a couple of the first pioneers to reform mental health care in the late 1700s and early 1800s<sup>13</sup>. They started a movement which would treat mentally ill patients as human beings with dignity, compassion, understanding, and care. These humanitarian changes in the early nineteenth century began psychiatric care as a treatment option of mental disorders.

Over the years mental health care began to focus on the psychological well-being of the patients and hospitals became less confinement-like and treatment was deinstitutionalized<sup>13</sup>. There are now more community- and school-based treatment options to accommodate those who have mental disorders. This treatment plan attempts to have the clients live in normal, healthy environments with little displacement as

possible. However, despite the progress psychologists made in the psychopathological field, the stigma of mental illnesses is still present. Stigma is characterized by four primary components. These characteristics distinguish people with mental disorders and label them, as “crazy,” for instance, which is linked to undesirable or deviant attributes (e.g., “crazy” people are unstable, aggressive, and dangerous). These people are then viewed as different, or outsiders, which can lead towards discrimination (e.g., a clinic for “crazy” people cannot be built in our neighborhood)<sup>13</sup>. This ideology continues to be deeply rooted in our society and is shown in healthcare, insurance, and policies. Policies continue to show evidence of discrimination against less able-minded individuals and can clearly be seen in documents such as the Affordable Care Act when medical care dominates conversations about health. Further, mental health has either been erased from policy, or synonymous with medical care.

### ***The Importance of Children’s Mental Health Care***

Children’s mental health is important because there are millions of children that are suffering from preventative and maintainable mental disorders. By having an effective and equitable mental health system, underserved youth will be able to live higher quality lives. Also, by having a mental health care system that is preventative, there would be a dramatic increase in societal benefits. There will be fewer children occupying juvenile halls and hospitals, which is more costly than preventative care. Their communities would benefit as well because more children will graduate high school and contribute to the community. Lastly, society as a whole would benefit because a large group of individuals would now be healthy and be able to positively contribute to the general public.

### *Limited and Low Quality of Services*

Previous studies have shown that there are a number of risks when living in low-income communities<sup>14</sup>. Areas that lack the infrastructure to provide protection and services that are necessary for normal development jeopardize the physical and mental well-being of a child. Yet, many families living in urban areas are confronted with this issue that leads to inadequate housing, crowding, limited access to resources, high crime rates, and associated problems<sup>14</sup>. These structural conditions subsequently produce environments that can cause the development of an early onset of mental illness, including depression, substance abuse, and posttraumatic stress disorder<sup>14</sup>.

In addition to the high risk of developing a mental disorder due to the stress of living in low-income communities, there is also a vast disparity in who receives appropriate services. Previous studies show that low- and middle-income children receive less treatment than wealthier children<sup>15</sup>. Management and delivery of mental health services are, of course, inconsistent, insufficient, and less coherent for all children; low-income neighborhoods are especially underserved<sup>16</sup>. Studies also suggest that there are geographic and financial barriers when treating children in low-income families<sup>14</sup>. These differences in access and finance result from low socioeconomic status and its characteristics that influence the burden of care cost, proximity to treatment centers and

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<sup>14</sup> Black, Maureen M., and Ambika Krishnakumar. "Children in Low-Income, Urban Settings: Interventions to Promote Mental Health and Well-Being." *American Psychologist* 53, no. 6 (June 1998): 635-46.

<sup>15</sup> Cohen, Patricia, and Carl S. Hesselbart. "Demographic Factors in the Use of Children's Mental Health Services." *American Journal of Public Health* 83, no. 1 (January 1993): 49-52.

<sup>16</sup> Behrens, Donna, Julia G. Lear, and Olga A. Price. *Improving Access to Children's Mental Health Care: Lessons from a Study of Eleven States*. Report. Center for Health and Health Care in Schools, 2013.

clinics, and the availability of providers<sup>17</sup>. As a result, poor mental health is positively associated with low socioeconomic status<sup>17</sup>.

Furthermore, racial and ethnic minorities are disproportionately more likely to reside and attend school in these communities<sup>18</sup>. Additionally, when minority children do receive mental health care, the patient is usually in a very severe psychological state. Also, treatment is insufficient for children in these communities because of issues, such as inexperienced mental health professionals and non-comprehensive care. Often mental health treatment, especially those put in place due to emergencies, is not adjusted according to a child's racial and ethnic cultural values<sup>19</sup>. This causes a separation between clients and providers, ultimately making treatment less effective for minority children;<sup>12</sup> as well as misdiagnose youth of color due to inaccurate dominant cultural norms and values being the basis of diagnosis. It has been shown that low-income, urban neighborhoods have a vast amount of social inequalities; it is not surprising that these communities also lack the necessary services needed to prevent and treat mental disorders. I would also expect that due to the stigma of mental illness in society interacting with the lack of resources in low-income communities, the result is a large disparity in children's mental health care.

### ***Barriers to Accessibility***

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<sup>17</sup> Harris, Katherine M., Mark J. Edlund, and Sharon Larson. "Racial and Ethnic Differences in the Mental Health Problems and Use of Mental Health Care." *Medical Care* 43, no. 8 (August 2005): 775-84.

<sup>18</sup> Evans, Gary W. "The Built Environment and Mental Health." *Journal of Urban Health: Bulletin of the New York Academy of Medicine* 80, no. 4 (December 2003): 536-55.

<sup>19</sup> Griner, Derek, and Timothy B. Smith. "Culturally Adapted Mental Health Interventions: A Meta Analytic Review." *Psychotherapy: Theory, Research, Practice, Training* 43, no. 4 (2006): 531-48.

Low-income children face a multitude of challenges and obstacles in their daily lives. Children of color have an added number of barriers to overcome<sup>20</sup>. Poverty and the surrounding built environment affect the mental health of community members and can put youth at risk for developing mental disorders<sup>18</sup>. Environmental risk factors including poor housing quality, residential crowding, noise, crime, and air quality can negatively affect a child's psychological health. Social resources of community are also a factor in whether children develop mental disorders. Poor community resources negatively contribute to parenting and providing care for mental illness<sup>21</sup>. Part of community resources is ethnic and racial heterogeneity and integration; and these aspects directly contribute to adolescent mental health<sup>18</sup>.

Furthermore, "segregation [is] the key structural factor for the perpetuation of black poverty in the US<sup>6</sup>." Residential segregation adversely affects health both directly and indirectly because with white flight – white people moving out of communities of color – mainstream resources that are needed as basic necessities leave as well<sup>6</sup>. A measure of residential segregation is the dissimilarity index – "the percentage of a group that would have to move in order for that group to be evenly distributed across a metropolitan area<sup>6</sup>." For blacks in New York, the dissimilarity index is eighty-one, meaning that "eighty-one percent of New York's black population would have to move in order to achieve an equal integration rate." Due to segregation limiting the resources of communities of color and perpetuating poverty, children living in these low-income communities have greater risks of developing mental disorders and are restricted in the

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<sup>20</sup> Aneshensel, Carol S. "Toward Explaining Mental Health Disparities." *Journal of Health and Social Behavior* 50, no. 4 (December 2009): 377-94.

<sup>21</sup> Wickrama, K.A. S., and Chalandra M. Bryant. "Community Context of Social Resources and Adolescent Mental Health." *Journal of Marriage and Family* 64, no. 4 (November 2003): 850-66.

treatment and services they can receive. Living in these neighborhoods are barriers to access in care in itself.

Once a child is in treatment, they face more limitations in new settings which create the racial disparities in the use of mental health services. These barriers include availability of providers<sup>22</sup>, proximity to mental health facilities<sup>17</sup>, and quality of care<sup>15</sup>. This is a limited supply in child psychiatrists, especially those who are qualified and experienced. Most importantly, it must be noted that there is a lack of preventative mental health care, meaning that the few children who do receive treatment have grandiose, externalizing symptoms; whereas, youth with internal symptoms, do not receive services because there is no external disruption<sup>21</sup>. Of the extreme cases of children and adolescents who are referred to receive services, there are problems of access to mental health facilities and child psychiatrists because both are in short supply, especially in low-income neighborhoods. If a child does receive treatment from a psychiatrist, there is a great possibility that they are inexperienced and there is a lack of comprehensive care. More experienced psychiatrists usually do not work with Medicaid covered clients so that they can charge higher prices for their services.

Another reason for the limitation is because parents of different racial and ethnic backgrounds are more skeptical of psychiatrists and their child's mental disorder<sup>23</sup>. Often, psychiatrists will misdiagnose a child due to their lack of knowledge about the client's culture<sup>19</sup>. When basing a psychological assessment on society's norms and values,

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<sup>22</sup> Children's Health Fund. *Mental Health Care in New York State: Prescriptions for Policy Change*. Report. Children's Health Fund, 2008.

<sup>23</sup> Montoro-Rodriguez, Julian, Gregory C. Smith, and Patrick A. Palmieri. "Use of Community and School Mental Health Services by Custodial Grandchildren." *Family Relations* 61 (April 2012): 207-23.

diagnosing a person of color usually results in a misdiagnosis. This occurs because psychiatrists will attribute behaviors or circumstances that are normal within a child's culture to something uncommon and diagnosable<sup>14</sup>. Due to these occurrences, socioeconomic status is directly linked to patterns of use of mental health services. Further, people of color are significantly less likely to enter their child into mental health treatment than their white counterparts<sup>24</sup>. Furthermore, these barriers to mental health care access cause a large unmet needs which most commonly results in deteriorating mental disorders in adulthood<sup>25</sup>, homelessness<sup>26</sup>, juvenile detainment<sup>27</sup>, and suicide<sup>28</sup>. Clearly, children's mental health care must be reformed. These barriers to accessing quality mental health care can be solved through effective implementation of the ACA, ideally, raising the number of underserved children with access to mental health care.

### ***New York City's Problems***

New York has similar barriers preventing underserved children from receiving mental health services and treatment. More specifically, New York City has issues with consistent attendance, long waitlists, a lack of qualified professionals as well as extreme and reactionary care such as emergency hospitalizations and juvenile detainment. Long

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<sup>24</sup> McMiller, William P., and John R. Weisz. "Help-Seeking Preceding Mental Health Clinic Intake among African-American, Latino, and Caucasian Youth." *American Academy of Child and Adolescent Psychiatry* 35, no. 8 (August 1996): 1086-094.

<sup>25</sup> Evans, Gary W., and Rochelle C. Cassells. "Childhood Poverty, Cumulative Risk Exposure, Mental Health in Emerging Adults." *Clinical Psychological Science*, October 1, 2013, 1-10.

<sup>26</sup> Milburn, Norweeta G., Philip Batterham, George Ayala, Eric Rice, Rosa Solorio, Kate Desmond, Lynwood Lord, Javier Iribarren, and Mary Jane Rotheram-Borus. "Discrimination and Mental Health Problems Among Homeless Minority Young People." *Public Health Reports* 125, no. 1 (January/February 2010): 61-67.

<sup>27</sup> Evans-Cuellar, Alison, Larkin S. McReynolds, and Gail A. Wasserman. "A Cure for Crime: Can Mental Health Treatment Diversion Reduce Crime among Youth?" *Journal of Policy Analysis and Management* 25, no. 1 (Winter 2006): 197-214

<sup>28</sup> Honberg, Ron, Sita Diehl, Angela Kimball, Darcy Gruttadaro, and Mike Fitzpatrick. *State Mental Health Cuts: A National Crisis*. National Alliance on Mental Illness, 2011.

waitlists is the most prevalent issue because it restricts children from receiving services. These long waitlists are primarily due to the lack of qualified child psychiatrists and mental health care facilities. Often, the psychiatrists offering services at readily available access points are inexperienced and do not know how to effectively treat underserved youth. Consistent attendance to treatment appears to be equally problematic as long waitlists. Children have difficulty receiving care in after school programs because of different factors such as lack of transportation to the facility, or conflicting schedules with parents' work. After a certain number of appointments have been missed, the child is removed from treatment and must go back on the waitlist. Emergency room visits and juvenile hall detainment are extreme forms of reactionary care because they wait until a child has developed a mental disorder and their behavior becomes uncontrollable before treatment. This form of care does not completely treat the illness either. Emergency hospitalizations and juvenile hall detainment are temporary and do not teach the child how to maintain their illness to prevent another episode from reoccurring.

### ***The Economics of Children's Mental Health***

Between 2009 and 2011, more than \$1.8 billion was cumulatively cut for services for children and adults with mental disorders from state budgets. California and New York cut the most state funding for mental health services by \$587.4 million and \$132 million, respectively<sup>28</sup>. The two largest funding sources for mental health services are Medicaid, a joint federal-state health program, and general state funds administered by the state mental health departments. State general funding of mental health care acts as a safety net for people with mental disorders; once state funding is cut, those who do not qualify for Medicaid lose resources in order to receive the services. Due to this great

unmet need, individuals with mental disorders: struggle with homelessness, are placed in the juvenile and criminal justice systems, have frequent visits to emergency rooms and hospitals, lose critical developmental years in childhood, and result in premature death and suicides<sup>28</sup>.

Although, there are different implications of budget cuts in individual states, the general demand for mental health services increase when state governments have mental health budget reductions<sup>28</sup>. Some specific services that have been eliminated or downsized in the last fiscal years are: emergency and long-term hospital treatment, crisis intervention and stabilization programs, targeted, intensive case management services, supportive housing, clinic services for children and adolescents, and access to psychiatric medication<sup>28</sup>. State budget cuts to mental health services are also a threat to Medicaid. Federal Medicaid money is given to states to provide health programs and services to those who are eligible. However, when state funding for mental health care is decreased, the states that have combined federal-state services, and services that fall into the optional category of Medicaid are significantly consolidated or eliminated. Ultimately, budget cuts to mental health care leave a large population with unmet mental health care needs. Additionally, the most vulnerable of this population, underserved children, suffer the most from these cuts.

One reason that these cuts occurred was largely due to the United States recession of '07 to '09, calling for more resources to be allocated towards restoring the economy rather than mental health care. However, New York and California continued to make cuts to mental health services between fiscal year 2009 to 2012 with New York cutting \$204.9 million and California cutting \$764.8 million to their mental health care budgets

during this time period<sup>29</sup>. Currently, New York City allocates \$970 million for the Administration for Children's services and \$809 million funds the department of Health and Mental Hygiene<sup>30</sup>. Yet, it is unknown how much is needed in collaboration of each city department to budget for an equitable, coordinated, and easily accessible mental health care system for underserved children.

### **Limitations to Previous Research**

Previous studies and a brief review of health care policies and programs demonstrate that the mental health care system needs extensive improvements. Particularly, children's mental health care appears to be at an inadequate, underdeveloped state. My research into the Affordable Care Act and its implementation on the most vulnerable population in the United States should clarify where improvements can be made to reform health care into a more comprehensive and equitable system. Because there is little literature on the effects of mental health policies on underserved children, specifically in their psychological development and quality of life, my research will be very significant. There are many facets in the manifestation of a mental disorder and aspects of life in which it affects. The stressors that are associated with poverty and living in low-income communities play a large role in mental health. Additionally, because there is a stigma linked to mental disorders, children with mental illnesses are less likely to be treated and instead will go through different avenues of containment, such as through the juvenile justice system. In this research I intend to show how the Affordable

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<sup>29</sup> Honberg, Ron, Angela Kimball, Sita Diehl, Laura Usher, and Mike Fitzpatrick. *State Mental Health Cuts: The Continuing Crisis*. Report. National Alliance on Mental Illness, 2011.

<sup>30</sup> Bloomberg, Michael R., and Mark Page. *The City of New York Executive Budget Fiscal Year 2014*. Office of Management and Budget. 2014.

Care Act will affect underserved children's mental health care in Los Angeles county and New York City. I will also include several recommendations to make children's mental health care more accessible and equitable to underserved children. Lastly, we must consider that a thorough and comprehensive change in the mental health care system will address multiple departments within the federal, state, and county governments.

## **Hypothesis**

The mental health care system is very inefficient and not effective. There is a large unmet need in children's mental health care. It does not appear that the ACA will be able to bridge the multiple gaps and break the barriers that inhibit underserved youth from receiving treatment. However, the ACA seems to have great potential and is a step in the right direction in order to create an equitable, culturally comprehensive, and coordinated system for New York's youth. Based on the past and current structure of children's mental health care, I expect that the ACA will increase the number of children in the system, but there will not be enough facilities to fulfill the need of newly Medicaid-covered children. However, I predict the ACA will also dramatically increase the quality of care for the underserved. The mental health care professionals I interview should have definitive and clear information about the impact the ACA will have on mental health services for underserved children.



## **Methods**

## Methods

Due to the genetic and environmental causality of mental disorders I chose to approach child mental health care in a similar fashion from a holistic and culturally comprehensive perspective. An incorporation of both quantitative and qualitative methods was used for data collection. Statistics about poverty and low-income families were taken from the United States Census reports and databases from the years of 2010 to 2012. The majority of this research is qualitative, with one case study, document analysis, and in-person interviews. I conducted thirteen interviews total, nine in New York City and four in Los Angeles. Of the New York interviews, I interviewed five direct service providers and four mental health policymakers from various offices situated within New York City's mental health care system. In Los Angeles, I conducted one interview of a policymaker and three interviews of mental health service providers.

Qualitative research was the best measurement for me to properly investigate the climate and overall state of child mental health care in New York City. New York is my case study because this state, after California, cut the second most funding for mental health care for adults and children. New York City also has the largest public school district in the country, while Los Angeles has the second largest school district. Thus, in essence, policy recommendations to these states should affect the most children. Because California and New York have similar state policies and impact the largest number of children, they are two cases where holistically researching children's mental health care is most pertinent.

In order to determine how the Affordable Care Act would impact children's mental health care, I performed document analysis. I analyzed the ACA as well as related state and federal health care policies such as the Mental Health Parity Act, Patient Protection Act, and the Child Health Insurance Program. These laws are either specialized for children's health care, mental health care, or a combination of both on the federal or state level.

Lastly, I conducted in-person interviews of several mental health professionals. In addition to interviewing mental health care direct providers, I interviewed professionals who work closely with and analyze health care policies and the Affordable Care Act. *A list of the subjects, job titles, and agencies is located in Appendix 2.* I believe that making the interviewees feel most comfortable increases cooperation, a person's willingness to share and speak openly. Thus, I made interviews semi-structured and informal.

Interviews included questions of both facts and information that the person could provide and their opinions on the current child mental health care system and the implementation of the ACA. Examples of questions are: what impact will the ACA have on your organization or how will the implementation of the ACA affect children's mental health care. Generally, I asked the same questions to mental health professionals and health care policy analysts, with a few exceptions. These variations in questions were mainly included because each person had a different area of expertise, especially between disciplines. Additionally, mental health professionals and policy analysts approached this topic from two different points of view and it was necessary to adjust interviews accordingly. Ideally, I expected that policy analysts would best explain health care

policies and their intention; whereas, mental health professionals would describe how these laws are practiced in a daily setting of a child's life.



## **Findings**

## **Findings**

For my primary research I interviewed five mental health care providers and four mental health administrators in New York. In order to make a clear comparison between New York City and Los Angeles County children's mental health care, I also interviewed an individual from Los Angeles County Department of Mental Health and three mental health service providers. The purpose of these interviews was to determine the impact the Affordable Care Act would have on children's mental health care once it was implemented at the beginning of 2014. However, I found that the mental health professionals I interviewed are not certain as to how the ACA will influence mental health care for children. It appears that due to the ACA being a new policy, and its implementation not taking effect until mid-2014, making conclusions on the state of children's mental health care will be premature and inaccurate. Substantially, allowing at least a year or two of operations is essential in the proper assessment of the effect of the ACA on children's mental health care. The following are common and unexpected elements I found while investigating the Affordable Care Act and its effect on mental health care for underserved children.

### ***The Affordable Care Act***

The Affordable Care Act has ten titles that focus on reforming the healthcare system. Provisions to the ACA primarily address medical health insurance, although there are a few specific areas which involve children's mental health care. It must be noted and acknowledged that many of the provisions of the ACA will have a general effect on children's mental health services (e.g. the expansion of Medicaid), however this

particular analysis of the ACA will be of specific sections that address children's mental health care.

Federal law – the Mental Health Parity Act – prevents health insurers from discriminating against those who have mental disorders. It ensures parity to people with mental illness by requiring health insurance providers to have equal coverage for medical and mental health care. Due to this law and increased emphasis on physical health in comparison to mental health, mental health care is not addressed frequently in the ACA. Often healthcare is used to incorporate both medical and mental health. However, the negative stigma that is associated with mental illness is still prevalent, and a greater emphasis is placed on medical care throughout the document.

Title II focuses on improving the access to healthcare through Medicaid. Subtitle A has a section on individuals who earn less than 133 percent under the federal poverty line and the mental health parity of mental health services for everyone. Subtitle B is about the “enhanced support for the Children’s Health Insurance Program (CHIP)<sup>31</sup>”. Although mental health care is included in CHIP, under Subtitle medical insurance was only mentioned. Subtitle C concentrates on the simplification of enrollment into CHIP and Medicaid. This is important for families with multiple children in the home, especially since many mental disorders are biological – siblings carry the same traits for mental illness<sup>31</sup>. Simplifying the process to enroll in Medicaid and CHIP allows more families access to care. Section 2713 includes coverage of preventative health services for children, adolescents, and teens, but does not specify what type of health care. Section 2714 discusses the extension of dependent coverage, granting teens nearing the age of

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<sup>31</sup> H.R. 3590 (The Affordable Care Act), 111th Cong., U.S. Government Printing Office (2010) (enacted).

adulthood to stay on their parents' insurance. Section 2717 ensures the quality of care and includes medication, treatment services, effective case management, and coordinated care as some of the ways to increase the quality of health care. However, again, this section did not specify between medical or mental health care. Section 5306 regards mental and behavioral health education and training grants<sup>31</sup>. This awards grants to institutions who recruit students for education and clinical experience in mental and behavioral health. This will incentivize more people to become psychiatrists, which is beneficial in an area where child psychiatrists are limited. Section 5604 gives incentives for creating coordinated and integrated services by co-locating primary and specialty care in community-based mental health settings. Section 4101 awards school-based health centers in order to promote an incline in their development. In this section, school-based health centers are to administer "comprehensive primary health services, [including] mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs<sup>31</sup>." *For more information about the ACA and its expansion of Medicaid eligibility and programs for underserved children see Appendix 1.*

Each of these sections within the ACA affects a specific aspect of children's mental health care which attempts to improve the system. This document analysis is important because it answers a portion of my research question in terms of how the ACA plans to change the system. However, we must acknowledge that although these provisions of the ACA appear to make strides towards an equitable mental health care system for underserved children, implementation of this law will cultivate in a different

form. It is not only the policies that must change in order for an equitable and coordinated system to evolve, but attitudes towards mental disorders and low-income families must change as well in order to increase access to care and culturally competent treatment. Additionally, the ACA is a very large and complex federal law, leaving many unanswered questions, such as: “How will this fit into the existing mental health care system?” “In exactly what ways will children’s mental health care be affected? How much more funding will there be? Does the city plan to build more mental health care facilities for children?” The best individuals to answer these questions are those who work within the New York mental health care system.

### ***Impact of the ACA***

I interviewed eight New York based mental health professionals and one state assemblywoman. Yusylin Hsin and Rue Zalina Watkins are from the Mental Health Association of New York City through the Coordinated Children’s Service Initiative. Heather Mermel is from the Coalition for Behavioral Health Agencies. Assemblywoman Michaëlle Solages represents the 22nd district of New York State. The service providers I interviewed were primarily based in Long Island; however each clinician has been working in the mental health service field for over twenty years throughout New York City and had a developed understanding of the city’s mental health system. Dr. Roy Laird is from Children’s Aid Society, Andrew Malekoff is from North Shore Child and Family Guidance Center, and Cathy Menzies, Dr. Ed Dana, and Sharee Lewin are from Martin De Porres School. Each agency represents a different component of the children’s mental health care system. As previously stated, analyzing the ACA governmental document does not fully offer an understanding of the health care system. By interviewing

professionals from each facility I can give a more comprehensive analysis of the effect of the ACA on New York's mental health care for underserved children.

Passing the Affordable Care Act caused commotion last year as many members of Congress disagreed on budgeting for the law, resulting in a government shutdown for 16 days in October of 2013. After numerous efforts, the crisis was resolved with an implementation date of January 1st 2014. However, after several months of preparation for an easy transition and a few weeks after the initiation of the ACA, my participants of this study remain unaware of its impact on children's mental health care for underserved populations. Cathy Menzies<sup>32</sup>, a licensed clinical social worker at a school-based mental health facility at Martin De Porres School, located in Elmont, New York, a private practitioner for 20 years, had absolutely no understanding of the ACA, any of its fundamental basics, or how the children at her school or clients would be affected by its implementation. In fact, the recurring response I received from mental health professionals was that they were unclear as to how the ACA would affect children's mental health, demonstrating a lack of information and education regarding its provisions. In contrast, only the mental health care administrators who work closely with mental health policies and play a role in the creation and implementation of mental health care laws felt they had adequate knowledge about the ACA. Yet, the clinical professionals who directly provide services to children with mental disorders do not have direct information about the ACA, nor where to find it, and have difficulty explaining the policy to the parents of their clients.

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<sup>32</sup> Menzies, Cathy. "Menzies Interview." Interview by author. January 13, 2014.

This power dynamic of who has knowledge about the changing structure perpetuates the large divide between those who are administrators and direct providers of mental health care. The reform to health care continues to create gaps between the top administrators and the providers who work on the ground level with the clients. It is clear that there is not an effective level of communication between these groups when those at the top of the hierarchy have a better understanding of the future of children's mental health care than those at the bottom. The interviewees who are city and state officials represent those at the top with the most influence and power over mental health policy. These are also the people with the most knowledge of the ACA. By contrast, the interviewees who directly treat children with mental disorders represent the bottom of the mental health care structure. From the top-down perspective, the ACA will largely reform health care in New York and there will be an increase in health care coverage. However, the top-down perspective is one-dimensional and usually excludes other factors, such as socioeconomic status and race, which are inherently infused and substantially shape the mental health care system. Therefore, I chose to incorporate further discussion of the bottom-up perspective, which is required in order to analyze other components of the mental health care system.

In contrast, the bottom-up perspective has an opposing narrative. Although there are some agreements about health care coverage, providers such as clinicians, therapists, and other staff members directly providing care for children with mental disorders state that the lack of knowledge will prevent many families who are now eligible for Medicaid from receiving funding. When underserved communities are included in the conversation, a larger disparity of who is privileged with information occurs. I found that there were

more divides and disparities between those who work directly with underserved mentally disordered children and the agencies who implement the law.

Heather Mermel<sup>33</sup>, the director of city and federal policy and advocacy of the Coalition for Behavioral Health Agencies, stated that New York State is currently undergoing a Medicaid redesign where the state's government will be transitioning certain populations to the managed care system. Medicaid managed care is a classification of Medicaid which is supposed to contain coverage costs in order to relieve state expenditure. Managed care divides costs into "25% local, 25% state, and 50% federal Medicaid coverage," said Mermel<sup>33</sup>. Despite this insight into the ACA and how it will be established within the current structure, Mermel explained that she still look forward to the exact results of how the Affordable Care Act will impact children's mental health care. Essentially, the Affordable Care Act only reforms the health insurance component of an entire health care system.

However, health care is not a singular system. There are many complex aspects which come into play the overall structure of the health care system. Treating the health care system in this one-dimensional fashion is the reason why there is limited access to services in low-income communities. Thus, the whole system must be reformed in order to truly create an equitable and efficient system, which includes health care coverage, as well as equal access to health care through schools and clinics, and increased quality of care with culturally competent and coordinated care.

### ***The ACA is Just the Beginning***

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<sup>33</sup> Mermel, Heather. "Mermel Interview." Interview by author. January 14, 2014.

In essence, the structure of the health care system was not prepared for smooth and effective transition into the ACA. An efficient transition into the ACA would address issues that specifically affect the uninsured, such as limited access to facilities, cultural incompetence, lack of child psychiatrists, or non-coordinated care. It appears that because the health care system is inefficient and inaccessible in combination with the ACA which only addresses one component of the health care system it is unclear how the implementation of the ACA will affect children's mental health care. Fundamentally, a holistic approach is needed to address other factors that play into the disparities in mental health care. Andrew Malekoff<sup>34</sup>, the CEO of North Shore Child and Family Guidance Center in Long Island, explained that the ACA promises to increase coverage to a larger group of underserved children, which should also make children's mental health care and services more accessible, "that is, on paper this should happen, but I am unsure of how it would be implemented, monitored, and enforced." Malekoff makes a strong argument, which is shared with most of the mental health professionals I interviewed. The ACA seems as if it will benefit a large portion of youth however it is probable that it will not make as great an impact as predicted. Healthcare did not address mental health effectively before the ACA, and now it appears that it will continue to have an inefficient system unless more systemic changes and restructuring occurs.

"It will depend," according to Malekoff, "on whether health insurance companies have adequate networks of care. Network adequacy refers to whether or not an insurance provider in a particular geographic region has enough child psychiatrists and other mental health practitioners on their rosters who will work with children with serious emotional disturbances and their families. This work is more labor-intensive which scares private practitioners and child psychiatrists away given the relatively low rate of reimbursement by commercial insurance companies as compared to current Medicaid rates. They would rather take out-of-pocket payments."

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<sup>34</sup> Malekoff, Andrew. "Malekoff Interview." Interview by author. January 15, 2014.

Although the effects of the Affordable Care Act are unknown, Malekoff's sentiment towards its implementation is shared by many. Malekoff added that, "Monitoring and enforcement of network adequacy is essential. If private insurers do not demonstrate network adequacy, then steps should be taken by advocates and government officials to remove their license to issue insurance." Nevertheless, the experts I interviewed are optimistic about the ACA and hope that increased coverage of mental health care will afford a rise in access to care as well. However, they remain skeptical. Many professionals appreciate the ACA for expanding health insurance coverage to underserved children. They believe that this expansion will address the large unmet need of underserved children who previously were not eligible. Dr. Roy Laird<sup>35</sup>, the director of the Bronx Children's Aid Society, further elaborated that because more children will qualify for Medicaid, clinics such as Children's Aid Society could better provide mental health care because Medicaid is easier to work with than private, commercial insurers.

The passing of the Affordable Care Act has sparked the beginning of health care reform in the United States. It takes strides towards universal health care and provides health insurance coverage for those who cannot afford it. Despite its monumental passage and the government shutdown of 2013, the Affordable Care Act is merely the initial stepping stone on the pathway to an equitable health care system, especially when considering reforming mental health care. Dr. Ed Dana<sup>36</sup>, the executive director of Martin De Porres School, and others acknowledge that the ACA "is a start," however, it will take much more than one or two laws to change the system. Additionally, mental health care shows larger disparities of inequality and quality of care than medical care due to the

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<sup>35</sup> Laird, Roy. "Laird Interview." Interview by author. January 15, 2015.

<sup>36</sup> Dana, Edward. "Dana Interview." Interview by author. January 13, 2014.

stigma associated with mental disorders. Overall, the general mentality towards the Affordable Care Act has been one of hope. Those working in the mental health field hope that the ACA can serve as a bridge into better medical and mental health care which will increase access and availability to care, improve quality of care, and essentially prevent health issues from occurring in the greater population as well as for underserved children. However, because of the lack of education in New York about how the ACA will be implemented, mental health professionals are hoping for a smooth transition into a reformed health care structure. Essentially, mental health professionals are waiting to see how the ACA will unfold in its implementation in the next couple of months. These experts anticipate that the ACA will only slightly make a difference in children's mental health care. Additionally, the providers who I interviewed expressed that they are less inclined to have faith in the ACA without further knowledge of the altering system because it seems as though the waitlists will only get longer and unmet need will grow larger with an unstable safety net.

### ***Changing Children's Mental Health Care: A Shift towards Medicaid Managed Care***

In addition to the skepticism of the implied positive aspects of the ACA, several participants suggested that the children's mental health care system is currently changing and will be different in a few years, possibly before any noticeable transformation from the ACA could be made in the children's mental health care system. Heather Mermel stated that New York State is currently undergoing a Medicaid redesign where the state's government will be transitioning certain populations to the managed care system. Medicaid managed care is a classification of Medicaid which is supposed to contain coverage costs in order to relieve state expenditure. Managed care divides costs into

“25% local, 25% state, and 50% federal Medicaid coverage,” said Mermel<sup>33</sup>. Essentially, managed care makes “providing care more difficult,” Dr. Laird explained.

Dr. Roy Laird has been directing mental health treatment for over 30 years. He has been working at Children’s Aid Society, which directly provides medical and mental health services to children and adolescents, for eight years. He elaborated that insurance limits access to services, especially in New York. When creating the Medicaid managed care, the state of New York opted for a free market model of health insurance coverage through Medicaid. In addition, Medicaid managed care insurance providers and facilities with which they contract can sometimes limit a child’s access to services. Furthermore, Malekoff clarified that there is no mandate for health care facilities and health insurance companies to contract with one another. Dr. Laird<sup>35</sup> offers an example of a boy who may need mental health services and is covered through Medicaid managed care: there is a strong possibility that he will not be able to receive the care that he needs because his specific insurance company may not cover services provided by his nearest mental health facility; thus, making the provision of services to underserved children a challenge. This scenario also identifies several common problems faced by those from low-income communities. If the boy cannot receive treatment at the nearest clinic due to his insurance, the only other clinic in his neighborhood might have double the number of children on the waitlist or could be too far away for him to reach by public transportation. This would increase the likelihood of inconsistent attendance, forcing him back on the waitlist, and further delaying his treatment.

Furthermore, transitioning the children’s mental health system into Medicaid managed care does not appear to be generating the results that mental health care

providers seek. In fact, it may inhibit care to underserved children. The Medicaid managed care system essentially directly reflects the very inequitable and inefficient system it is supposed to solve. Although it has the potential to significantly improve access to care while containing program costs, New York State has not created an efficient health care system in which this occurs. It is especially high in risk to transition Medicaid covered mental health services to a managed care model. Furthermore, this shift occurring simultaneously during the implementation of the ACA seems haphazard because the number of Medicaid recipients is increasing while the number of those in the current safety net system is decreasing. Because the Medicaid managed care model in New York is undergoing expansion, it is crucial that the state creates a partnership between providers, consumers, and health care companies in the transition – thus, establishing an easily accessible and efficient health care system in New York possible.

### ***Unexpected Findings***

In contrast to previous findings, Rue Zalina Watkins<sup>37</sup> and Yusylin Hsin<sup>38</sup> stated that Affordable Care Act money would not be allocated for children's mental health services at all. Watkins, an education services consultant, and Hsin, project coordinator, both from the Mental Health Association of New York City, Coordinated Children's Service Initiative (CCSI), argued that, in fact, New York is shifting children who would be eligible for Medicaid through the ACA to Child Health Plus (*see Appendix 1*), a New York state health care insurer for low-income families. Watkins<sup>37</sup> clarified that Child Health Plus has more resources for children, while the ACA has specific options for

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<sup>37</sup> Watkins, Rue Zalina. "Watkins Interview." Interview by author. January 7, 2014.

<sup>38</sup> Hsin, Yusylin. "Hsin Interview." Interview by author. January 7, 2014.

adults. Hsin<sup>38</sup> agreed that Child Health Plus separates the child from the family coverage, meaning that parents and children are enrolled in two separate programs through the state government. Before a child is considered for services offered by the ACA, they are first examined for eligibility in Child Health Plus before they are included them on their parents' coverage plan. Due to the past structure of New York's children's mental health care system and policies, there is a strong possibility that the state plans to implement the ACA for adult populations and transition children to a different system. This is a viable option because Child Health Plus is a well-established and stable program that has resources to provide. Transitioning children to Child Health Plus could have some advantages that could not be seen for another few years with the ACA. Additionally, it is possible that this process could help children receive the services they need at a faster pace. For example, a certain amount of ACA money is budgeted to Child Health Plus and because the system is already in place, the children added to this insurance receive their benefits quicker than they would have if they were enrolled into Medicaid.

Contrary to the previous findings based on interviews, New York has made strides towards having a smooth implementation of the ACA on the state and local governments. New York State created a health exchange, similar to Covered California<sup>39</sup>, in which new eligible New Yorkers can apply for Medicaid benefits and affordable health insurance. NY State of Health is the official health plan marketplace where New Yorkers can go to compare different health plans and apply for Medicaid and Child Health Plus health care coverage<sup>40</sup>. Additionally, several state laws have passed in order to adopt the

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<sup>39</sup> "California Health Benefit Exchange and Department of Health Care Services." Covered California. Accessed October 2013. <http://CoveredCA.com>.

<sup>40</sup> New York State of Health. Accessed October 2013. <http://www.healthbenefitexchange.ny.gov/>.

ACA and have a simple conversion process. In 2011, New York State legislature passed A8460/S5800 which updated the state's insurance and public health laws. This included the federal provisions of the ACA regarding health insurance policies and contracts. More specifically, it expands "prescription drug coverage, pediatric, and preventive care, increases the age of dependent children, provides for choice of health care providers, and prohibits lifetime and annual coverage limits, as well as bans those with pre-existing conditions from being rejected from insurance companies<sup>41</sup>." This bill shows that New York is attempting to restructure the system around health care and promote reform. However, after speaking with mental health professionals, it is clear that New York has a significant amount of work to be done in order to establish an equitable and comprehensive mental health care system for underserved children.

Although other mental health experts did not mention this possible shift in children's mental health care, many agreed that there would be a large transformation in insurance coverage within the next two years. However, many professionals did not know the exact alterations currently taking place. Instead, I found that the lack of education around the implementation of the Affordable Care Act has caused a large disparity between policymakers and the community and providers who are more directly affected by the act. This uncertainty extends to children's mental health care as a whole. Some mental health care professionals explained that children's mental health care is shifting towards a Medicaid managed care model; while others implied that the system is completely moving children to Child Health Plus and will not receive ACA benefits at all.

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<sup>41</sup> New York State Senate. S5800-2011 (2011) (enacted).

## *Other Findings*

Although the professionals I interviewed could not completely explain how the ACA would affect children's mental health care, they were able to tell me the issues each faced when attempting to provide service to underserved children, either directly or indirectly. These problems include limited access to care, non-preventative entry points into the mental health care system, inconsistent attendance to treatment, long waitlists, and detainment in the juvenile justice system. Due to the similar structure of the mental health system, Los Angeles County faces many of the same issues as New York City. Susan Moser<sup>42</sup>, the departmental resources manager of the Los Angeles County Department of Mental Health, shared that, "staffing does not always meet the volume of needs for [children]<sup>42</sup>." Moser also commented that it was too early in the process of implementation and families continuing to sign up for insurance, to be able to know exactly how the ACA would affect children's mental health care in Los Angeles County. However, she too, remains hopeful. Weston Taussig<sup>43</sup>, the lead therapist of Pacific Clinics at the Hurlbut location and private practitioner, stated that the ACA "will have both a positive and negative impact<sup>43</sup>" because although there will be an new underserved population that will receive treatment, there will still be a group of other children who will not be served. Vicki White<sup>44</sup>, the program director of Pacific Clinics at the Hurlbut location, further explained that although there is an increase in clients, many facilities will not be built, which was later confirmed by Moser, meaning that there will be longer waitlists for the children now eligible for MediCal mental health services. White also

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<sup>42</sup> Moser, Susan. "Moser Interview." Interview by author. February 7, 2014.

<sup>43</sup> Taussig, Weston. "Taussig Interview." Interview by author. December 12, 2013.

<sup>44</sup> White, Victoria. "White Interview." Interview by author. December 12, 2013.

stated that more progress is needed quickly in order to grant other children the ability to receive services. In short, both New York and Los Angeles County mental health care professionals share the same sentiment and issues they must overcome when planning to provide mental health care to underserved children through the ACA. Due to the similarities in children's mental health structure and issues within this system between Los Angeles and New York City, many of the recommendations for New York will be applicable for Los Angeles County as well.

The future for mental health care for underserved children appears to be very unclear. There is great potential for the Affordable Care Act to develop into a coordinated and comprehensive mental health care system equally accessible to underserved children. Based on these findings the mental health care services future is presenting itself to follow a continuous, circular pattern. Many of the issues in children's mental health care are due to the state attempting to consolidate costs, which causes a large disparity gap in access to care, along with a lack of quality of care. Once other governmental departments are incorporated into mental health reform, there will be a more positive outlook for the future of children's mental health care.



**Recommendations**

## **Recommendations**

Based on my findings, I cannot assess the effectiveness of the Affordable Care Act and evaluate necessary policy changes in order to create an equitable and efficient children's mental health care system. Although the first part of my research question is left unknown, this section serves to answer the second part of my research question: in what ways can we make the mental health care system more equitable for underserved children through the ACA? Thus, I will provide policy recommendations needed to be put in place in addition to the ACA in order to have a coordinated and comprehensive children's mental health care system that is equally accessible to all children. These policy changes and list of best practices are hypothesized to be the most effective to translate an equitable children's mental health care system into tangible solutions.

### ***Educating Parents and Service Providers***

To resolve the lack of education by families, there must be a push to educate families and providers the exact ramifications of the ACA. This can be done through specific outreach campaigns that target underserved populations, hosting trainings and/or presentations for service providers, or simply creating and advertising educational websites, pamphlets, etc. for parents and providers about the ACA's effects. It is estimated that 7 million Americans signed up for the ACA. The same method that was used to promote ACA signups should be the same method used to educate parents how their children's healthcare will change as well. The same strategies to educate parents and providers could be implemented in both New York City and Los Angeles. Additionally, this platform could be used to destigmatize mental disorders. Caring for mental disorders

will be easier when it is normalized and early intervention is set in place. Also, policies would include mental health care rather than strictly mentioning medical healthcare and truly give parity to mental health.

### ***Create Provision to Include Undocumented Children in ACA***

Undocumented individuals commonly do not receive benefits due to their status as a noncitizen. This extends into the healthcare system as well. However, one interviewee suggested that undocumented children be included in the expansion of eligibility of Medicaid. Due to New York's and Los Angeles's high rates of immigrants, including undocumented youth in Medicaid coverage would open access points to mental health care to this particular population of underserved children.

### ***Expand Provisions to Stipend Requirements of Child Psychiatrists***

Section 5306 incentivizes institutions to recruit students in higher education to train and receive clinical experience in mental and behavioral health. This provision should be extended to individuals seeking to become child psychiatrists. The professionals I interviewed also expressed that one reason why there is limited care and long waitlists is due to a shortage in staffing. Increasing child psychiatrists is a necessity in the growing population of mentally ill children that are now insured. Incentivizing individuals as well as institutions is the best method to raise the number of child psychiatrists that are needed to fill the gaps of the unmet need in New York and Los Angeles.

### ***Increase Provisions to School-Based Mental Health Care***

The primary issue in the children's mental health care system is its lack of access. Of the twenty-one percent of children and adolescents living with a serious mental illness, approximately seventy percent do not receive the treatment and care they need<sup>16</sup>. Furthermore, most of the children who receive care are the most troubled and have the most severe emotional disorders. Many mental health care professionals argue that school-based mental health care is the best service delivery model which would dramatically decrease the mental health care disparity. It would also help to eliminate other problems in the children's mental health care system such as inconsistent attendance rates, long waitlists, emergency hospitalizations, and juvenile detainment<sup>36</sup>. This policy recommendation can easily be funded, implemented, and sustained through state and local partnerships<sup>45</sup>. Furthermore, support for school-based mental health care and expanding mental health services at schools are the best solutions in order to increase access to mental health care that could extend to undocumented children, as well as create an equitable, efficient, and coordinated system.

School-based mental health facilities are schools which offer mental health treatment services to students in a school setting. The common model of school-based mental health services are organized in several components: a) the clinic is situated within the school, or is located near a school, b) a collaborative partnership between school district, health care providers, and insurance, c) the center administers thorough mental health services to children regardless of insurance provider, and d) each facility satisfies

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<sup>45</sup> Price, Olga A., and Julia G. Lear. *School Mental Health Services for the 21st Century: Lessons from the District of Columbia School Mental Health Program*. Report. Center for Health and Health Care in Schools, 2008.

insurance providers' requirements<sup>46</sup>. The organization of school-based mental health facilities grants equal access to mental health services and serves as an equitable delivery system for all students. It also serves as a system of preventative care. School-based mental health centers offer mental health assessments, screenings, early intervention, referrals, crisis intervention, and case management in addition to its therapeutic treatment services<sup>9</sup>. This prevents possible occurrences of mental disorders for children who are at greater risk of developing a disorder and installs a system of early intervention to inhibit and maintain some of the worse behaviors. It also solves issues of long waitlists, inconsistent attendance rates, emergency hospitalizations, and custody in the juvenile justice system. School-based mental health facilities also brings mental health care to vulnerable and underserved children, further highlighting the necessity of incorporating additional funding provided under ACA.

New York City has the largest public school system in the United States serving about 1.1 million students. Of this student population, about thirty-nine percent are Latino, thirty percent are Black, fifteen percent are Asian/Pacific Islander, and fourteen percent are White<sup>10</sup>. With the majority of New York students who attend public school being of color, increasing school-based mental health facilities will bring mental health care to a large number of children, thus, shrinking the disparity of access to care. Due to the differential stress exposure and access to psychological resources<sup>20</sup>, communities of color and children from low-income families are the most vulnerable populations to

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<sup>46</sup> Behrens, Donna, Julia G. Lear, and Olga A. Price. *Developing a Business Plan for Sustaining School Mental Health Services: Three Success Stories*. Report. Center for Health and Health Care in Schools, 2012.

manifest mental disorders and impaired behavior rates<sup>47</sup>. “While not an immediate solution to the need to improve access to high quality healthcare in itself, increasing the number of school-based [mental] health centers is a step in the right direction towards the ultimate goal of increasing school mental health and healthcare service provision to students and their families<sup>9</sup>.” Building more school-based mental health centers in New York City’s public and charter schools would address the barriers to mental health services for youth. The following are the primary barriers to mental health care access for many children in New York and the strategies in which school-based mental health care resolves these issues.

1. *Attendance*

Due to a multitude of factors, attendance in afterschool programs is very inconsistent in low-income communities of New York. Many children have problems with attending treatment after school due to differing factors such as transportation issues, parents having to work, or other restrictions due to other members of the family. For example, parents have trouble bringing their child to treatment when they have conflicting work schedules, or if another child becomes ill. School-based mental health centers resolve the attendance problem because children usually attend school every day. Essentially, these facilities ensure treatment throughout the day, several days a week.

2. *Long waitlists*

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<sup>47</sup> Guo, Jeff J., Terrance J. Wade, and Kathryn N. Keller. "Impact of School-Based Health Centers on Students with Mental Health Problems." *Public Health Reports* 123, no. 6 (November/December 2008): 768-80.

Another common problem in New York City is the large unmet need for children's mental health services. This unmet need results in long waitlists for treatment at various children's mental health care facilities around the city. School-based mental health centers could decrease the lengthy waitlists by increasing the number of children offered services. In addition to the issue of long waitlists, children who have missed a number of sessions are dropped from their programs and placed back on the waitlist to receive care. Granting access to a greater number of children through school-based mental health centers retains children in mental health care programs, as well as limiting the number of children forced to go untreated while on long waitlists.

### 3. *Emergency Hospitalizations*

Emergency hospitalizations and other forms of crisis interventions are one of the primary pathways into mental health care. These pathways are not ideal because they only provide reactionary and temporary care for the most extreme cases. This reactionary method of treatment does not incorporate preventative care to inhibit the negative behaviors that caused the hospitalization. Furthermore, the children who suffer from mental disorders, but do not project an external disturbance continue to not receive services. However, school-based mental health care acts as both early intervention and preventative services to avoid emergency hospitalizations. Essentially these treatment options are more cost effective than addressing the problem after children have already fostered severe mental disorders. Additionally, this gives the child a better quality of life by being able to avoid the development of a disorder, rather than treating them when their disorder is uncontrollable.

#### 4. *Juvenile hall detainment*

School-based mental health care would also prevent the high level of mentally impaired youth held in the juvenile justice system. Often schools that are not equipped to manage children with mental health disorders call the police in emergency situations that could otherwise be handled through crisis response teams affiliated with mental health providers in the school. Although the juvenile justice system provides mental health services to every child, this is not the ideal entry point into mental health care because it ruins a child's record and prevents opportunities for the future. School-based mental health care could also prevent juvenile hall detainment because they are well-equipped for mental disorder induced outbreak and episodes where the police would not be necessary; and instead a therapist would be called to intervene.

Financing school-based mental health center is the most difficult aspect in provisioning more facilities. The simplest way to fund school-based mental health care and ensure a self-sustaining system is to pool a number of different resources<sup>45</sup>. Financing school-based care can be done through Medicaid reimbursements, federal grants, and state and local governmental collaboration of the Department of Education, Office of Mental Health, New York Public Schools, and Department of Mental Health and Hygiene. There are several federal grants that specifically award institutions which has children's mental health services such as System of Care Expansion Planning Grants, Circles of Care VI, Project LAUNCH, and Minority Fellowship Program<sup>48</sup>. Sharee

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<sup>48</sup> "Grant Announcements." Substance Abuse and Mental Health Services Administration. Accessed October 2013. <http://www.beta.samhsa.gov/grants/grant-announcements>.

Lewin<sup>49</sup>, the school psychologist of Martin de Porres School, explained the dilemma of school-based mental health facilities: because these schools operate through the public school system, they are not allowed to bill students for their services. Most school psychologists are primarily useful to assess and administer psychological tests to children in order to treat them onsite. However, a city-state partnership would provide funding for school-based mental health care and is essential in the development of school-based mental health care. Several case studies in Bucks County, Pennsylvania, Minneapolis, Minnesota, and Washington, DC<sup>46</sup>, as well as the school-based mental health clinics already established in Los Angeles and New York show that instituting more self-sustaining facilities is possible.

Los Angeles Unified School District is the second largest school district in the country, serving approximately 677,538 students. The demographics of Los Angeles's public schools are similar to those of New York City. Seventy-three percent are Latino, ten percent are Black, nine percent are White, and six percent are Asian/Pacific Islander<sup>12</sup>. Additionally, of the 1,124 public and charter schools of LAUSD, only eight of those are school-based health centers and seven are wellness centers<sup>12</sup>. With parallel demographics and size of the school district, school-based mental health care provisions made in New York can easily be implemented in Los Angeles as well.

### ***Restructure Children's Mental Health Care System***

Ultimately, the children's mental health care system must be restructured in order to bring equality. In addition to promoting mental health awareness and destigmatizing

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<sup>49</sup> Lewin, Sharee. "Lewin Interview." Interview by author. January 13, 2014.

mental disorders, we must create a structure in which children are not discriminated against due to their race or class. Much of the reasoning behind why there is limited access to mental health care for underserved children is because there are not available facilities to treat them, or the quality of care is low due to cultural incompetence or lack of experience by the clinician. Sections 2717 and 5604 incentivize quality of care and coordinated treatment, however much more must be done in addition to these measures to create quality and coordinated care. The ACA changes one aspect of the mental health system: insurance. Yet, as mental health professionals speculated, having insurance does not necessarily ensure care. There are many insured children who continue to not receive the treatment they need. In essence, structural changes in the different components of mental health services are absolutely necessary in order to establish an easily accessible, equitable children's mental health system. Such restructuring model would have: coordinated case management, integrated mental health services with primary medical healthcare, schools, and after school therapists, culturally comprehensive care, increased funds in order to raise mental health facilities' capacities and buildings, and expand mental health care in schools in both New York and Los Angeles.



**Conclusions & Future  
Research**

## Conclusions

Though there is not a clear, definitive result of the impact the ACA will have on children's mental health services in New York City, it is evident that in order to meet the high quality standards needed, much more than the ACA must change to have a fully comprehensive, coordinated, equitable, and efficient mental health care system. The ACA merely addresses the insurance aspect of healthcare other dilemmas exist such as issues of a limited number of child psychiatrists, the number of openings at mental health care facilities, efficient and effective treatment, and culturally competent care.

By expanding the eligibility requirements of Medicaid, the previously uninsured youth now have health insurance and a number of benefits that are associated with their coverage, but there is no point in having it if there continues to be preventative limitations to children receiving care. Before the ACA, children's mental health care showed that it was not well-equipped to address the needs of all children with mental disorders, resulting in a vast population of underserved youth. Now, it appears that the same framework that has not worked in previous years is being put in place for the ACA, and mental health professionals fear it is still not enough to address the unmet need. The reality is that one out of every ten children has a serious emotional disturbance<sup>3</sup>, while only about twenty percent of these disturbed youth receive treatment<sup>16</sup>. There must be a sense of urgency on this issue and the government has an obligation to provide quality care to these children. The best method is to evaluate services and treatment after a short period of time to assess the ACA's implementation and determine efficient and effective ways to fill the gaps in the other areas of New York's children's mental health care.

### **Future Research**

Due to the novelty of the Affordable Care Act, knowledge of implementation is limited. It takes time for policies to be implemented and because I began interviews a week after the ACA was to begin implementation, mental health care professionals and experts were unclear as to how it would exactly affect children's mental health care. However, after a few years – once the transition into the new mental health care system is complete – a more accurate analysis and assessment of the ACA can be done. Once the ACA is evaluated, policy changes can be implemented to create an equitable, efficient, coordinated, and culturally comprehensive mental health care system for underserved children in New York City.



**Appendix**

## Appendix

### **Appendix 1: Mental Health Policies**

#### **Federal**

##### *The Affordable Care Act*

On March 23, 2010, President Obama signed a health care reform, the Patient Protection and Affordable Care Act (PPACA), into law<sup>9</sup>. Under the Health Care Education and Reconciliation Act of 2010 (HCERA), the Patient Protection Act and Affordable Care Act (PPACA) and subsequent amendments, collectively referred to as the Affordable Care Act (ACA), is supposed to expand access to public and private health insurance while seeking to change the way health care is provided and paid for across the United States<sup>9</sup>. Through several provisions, the ACA will expand and improve health care services for low-income and uninsured Americans; estimating to cover approximately 5 million uninsured children and adolescents<sup>7</sup>. The following major provisions pertaining to children's mental health care are: eligibility, information technology systems and data, coordination with affordable insurance exchanges, benefits, community-based long-term services and supports, quality of care and delivery, and Children's Health Insurance Program (CHIP).

##### *Eligibility*

The Affordable Care Act expands Medicaid's eligibility to all children and their parents whose households' incomes are at or below 133 percent of the Federal Poverty Level, or an income of \$29,726 for a family of four in 2011. Medicaid and CHIP eligibility and enrollment will be simpler and coordinated with the Affordable Insurance Exchanges. This system enables individuals and families to apply for coverage using a single application and have all their insurance eligibility determined for all affordable health care programs through a single simplified process<sup>50</sup>.

##### *Information Technology Systems and Data*

The Centers for Medicare and Medicaid Services (CMS) developed a policy and financing structure designed to provide states with the proper tools to have a smooth transition of the January 1st launch date of the ACA. Investment into information technology systems and data is needed in order to ensure state Medicaid systems will be prepared immediate exchanges and expanded eligibility.

California's version of this system is called Covered California. The joint partnership of Covered California and the Department of Health Care Services creates a marketplace for health insurance and information about MediCal eligibility. Covered California is meant to increase the number of Californians with health insurance in conjunction with the implementation of the ACA, reduce the health care coverage costs, improve the quality of health care, and create a more equitable system; as well as provide

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<sup>50</sup> "Centers for Medicare & Medicaid Services." Medicaid.gov. Accessed October 2013. <http://www.Medicaid.gov>.

low-income Californians with affordable health care, including medical, mental health, substance abuse treatment services, and long-term care<sup>39</sup>.

Instead of a specific system to aid in the transition of state Medicaid systems and the implementation of the ACA, New York passed the S5800 bill, formerly known as A8460. It relates to the implementation of the ACA and creates a legal structure in order for a smooth transition for Medicaid enrollees. The purpose of the bill is to amend the Insurance and Public Health Laws to make changes required by the ACA. S5800 relates to prescription drug coverage, pediatric care, pre-existing conditions and preventative health care, it increases the age of dependent children, provides for choice of health care providers, and prohibits lifetime and annual coverage limits<sup>41</sup>.

### *Benefits*

The ACA makes various changes to the benefits provided to Medicaid enrollees. There are a number of benefits listed under the ACA, which are categorized into a mandatory group and optional group. Through the Medicaid program states must cover mandatory benefits, but have an option of providing the optional benefits. The mandatory benefit that pertains to children's mental health services is early and periodic screening, diagnostic, and treatment services (EPSDT). EPSDT is one of the only preventative and early intervention services provided through Medicaid. It allows for children to be screened periodically throughout their developing years for mental disorders and assigns treatment options as means for early intervention if a mental illness develops. Optional benefits relevant to children's mental health care are: prescription drugs, clinic services, inpatient psychiatric services for individuals under 21, clinic services, speech, hearing, and language disorder services.

### *Community-Based Long Term Services*

The ACA has multiple program and funding improvements to administer long term services and support in the home and community. "The law improves existing tools and creates new options and financial incentives for states to provide home and community-based services and supports<sup>39</sup>."

### *Quality of Care and Delivery*

The ACA seeks to improve the quality of care and the method in which it is delivered while reducing costs. It established The Innovation Center that is partnered with the CMS in order to develop and test innovative health care payment and delivery service models.

### *CHIP*

The ACA significantly extends funding for the CHIP through fiscal year 2015 and continues the program to 2019. Children with a family income between 100 and 133 percent lower than the federal poverty line will be eligible for Medicaid. However, states keep their ability to claim the enhanced matching rate.

The Affordable Care Act has the potential to break down the barriers low-income children face with mental health care. It addresses health care through several different entities which is necessary when creating culturally comprehensive laws. The ACA is a satisfactory beginning to health care reform. However, there are several institutional and systematic bodies of inequality that must be dismantled in order to ensure true change. These changes involve societal education which can substantially alter health care, insurance, and policies for the better. Additionally, previous mental health policies must be reviewed and enhanced when discussing mental health care reform. The following policies are federal and state laws previously passed.

### ***Mental Health Parity Act***

The Mental Health Parity Act gives parity to those with mental illnesses – requiring group health plans and health insurance providers to ensure that medical and mental health care are equal costs, treatments, and coverage. That is, health care providers must make mental health benefits equally comprehensive as physical health benefits. The Substance Abuse Equity Act is usually used in conjunction with the Mental Health Parity Act, which has the same requirements, except health services for substance abuse must be equitable to medical health care. Furthermore, both New York and California have their own state laws that are versions of these federal laws; Timothy’s Law and Mental Health Parity Law, respectively.

### ***Individuals with Disabilities Education Act (IDEA)***

Signed into law by former President George H.W. Bush on October 30th 1990, the Individuals with Disabilities Education Act (IDEA) is the nation’s federal special education law<sup>51</sup>. The primary purpose of IDEA is to ensure that public schools provide children with disabilities equal access to education. More specifically, it “requires every state to issue regulations that guide the implementation of the federal law with the state<sup>18</sup>.” IDEA requires that parents participate in the process equally with the school to determine if the child has a disability and special education is needed. However, every child with a disability may not qualify for these special education services. The disability must result in the student needing additional or different resources to participate in school. Eligibility requirements for IDEA is defined as a child with an intellectual or specific learning disabilities, hearing, speech, language, visual, or orthopedic impairments, developmental delay, emotional disturbance, autism, traumatic brain injury, multiple disabilities, or other health impairments<sup>51</sup>.

### **State**

#### ***Mental Health Services Act (MHSA) – California***

The Mental Health Services Act is a California law designed to expand and transform California’s mental health service systems. The state Department of Mental Health increased funding, personnel, and other resources to support county mental health programs in order to progress towards California’s goals for children, youth, adults, and

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<sup>51</sup> National Center for Learning Disabilities. Accessed October 2013. <http://www.NCID.org>.

families<sup>52</sup>. MHSAs impose a one percent income tax on personal income in excess of \$1 million, which was projected to support prevention, early intervention, service needs, and necessary infrastructure to effectively govern the mental health system. California's public mental health system offers community and hospital based services to children with a severe emotional disorder. These services include: rehabilitation and support, evaluation and support, vocational rehabilitation, individual service planning, residential treatment, medication education and management, case management groups, and wrap around services<sup>52</sup>.

## **Local**

It appears that the local, city governments of Los Angeles County and New York City do not have mental health policies; but instead administer mental health services in compliance with state and federal laws. These services are included in the following section.

## **Mental Health Care**

### *Medicaid*

“Medicaid is the single largest payer for mental health services in the United States. Although federal law does not contain explicit provisions concerning the exact types of mental health services that can be provided, all State Medicaid programs provide some mental health services to enrollees. There are several vehicles that States can use to support effective community mental health services in Medicaid<sup>50</sup>.” Medicaid and the Child Health Insurance Program provide health coverage to half of all low-income children in the United States. MediCal is California's department that distributes federal Medicaid funds in order to provide health care to low-income individuals.

### *Specialty Mental Health Services Consolidation Program*

The Specialty Mental Health Services Consolidation Program was implemented by California's Department of Mental Health for MediCal recipients receiving or in need of outpatient or medical professional mental health services<sup>53</sup>. This program expands the Psychiatric Inpatient Hospital Services Consolidation Program. Coverage for specialty mental health services is provided through Mental Health Plans (MHP) in the 58 counties. Children covered by EPSDT must have a mental disorder that can be corrected in order to qualify.

### *Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT)*

EPSDT is the only mandatory child mental health benefit offered through Medicaid. It provides preventative, mental, dental, and developmental health care for children under the age of 21. Under EPSDT, children receive early – assessing and identifying problems early, periodic – checking children's health at periodic, age-

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<sup>52</sup> California Department of Mental Health. Mental Health Services Act, Proposition 63 (2013) (enacted).

<sup>53</sup> “Specialty Mental Health Care Services.” Medi-Cal. Department of Health Services. Accessed October 2013. [Http://www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov).

appropriate intervals, screening – providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems, diagnosis – performing diagnostic tests to follow up when a risk is identified, and treatment control – correct or reduce health problems found<sup>50</sup>.

### ***Child Health Insurance Program (CHIP)***

The Child Health Insurance Program provides coverage to 8 million to children whose family incomes are too high to qualify for Medicaid, but cannot afford private health insurance. Similar to Medicaid, CHIP is administered by states, but is jointly funded by the state and federal government<sup>15</sup>. In California the state CHIP is known as State Child Health Insurance Program (SCHIP) or Healthy Families. In New York the state CHIP is known as Child Health Plus.

### ***Child Health Plus – New York***

Child Health Plus is New York State's health insurance for low-income households with children not eligible for Medicaid. Benefits covered by Child Health Plus pertaining to children's mental health care are: emergency care, prescription and non-prescription drugs if ordered, inpatient and outpatient treatment for alcoholism and substance abuse, and mental health<sup>54</sup>. Families with children insured by Child Health Plus are given a list of health providers near them. Providers may be a single doctor, group practice of several doctors, or community health center<sup>54</sup>.

Through the Department of Health and Mental Hygiene, New York City provides children and adolescents with multiple treatment options for mental health, including: information and referrals (Lifenet, Children's Single Point of Access, family resource centers), outpatient (clinic and day treatment) and inpatient (inpatient psychiatric units), community supports (early childhood mental health, case management, home and community based services waiver, adolescent skills centers), emergency and crisis (hospital psychiatric emergency rooms, mobile crisis teams, home base crisis intervention, intensive crisis stabilization and treatment), and community residential (residential treatment facilities, children's community residences) services<sup>54</sup>.

### ***Children's Single Point of Access (CSPOA)***

Children's Single Point of Access offers several different services to aid with children's health coverage, either by streamlining the application process, or in other mediums. The Family Based Therapeutic Intervention is one that pertains to children's mental health care. This resource is only offered in the Bronx. It provides free, short-term mental health care at the home to children with Axis I diagnoses, between the ages of 5-18. The program aims to stabilize homes and establishes strategies to accomplish goals related to the child's mental health<sup>55</sup>.

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<sup>54</sup> "Child Health Plus." New York State Department of Health. Accessed October 2013.  
<http://www.healthy.ny.gov>.

<sup>55</sup> "Children's Single Point of Access." Mount Sinai Health System. Accessed October 2013.  
<http://www.WeHealNY.org>.

### ***Community Residence***

Community residences are small therapeutic group homes with clinical services administered by community mental health programs<sup>54</sup>. These services are through the Office of Mental Health.

## Appendix 2: Mental Health Care Professional Participants

### New York Subjects

Yusyin Hsin

*Project Coordinator*

*The Mental Health Association of New York City, Coordinated Children's Service Initiative*

Rue Zalina Watkins

*Education Services Consultant*

*The Mental Health Association of New York City, Coordinated Children's Service Initiative*

Heather Mermel

*Director of City and Federal Policy and Advocacy*

*The Coalition of Behavioral Health Agencies, Inc.*

Assemblywoman Michaelle Solages

*State Assemblywoman*

*22<sup>nd</sup> District, New York State*

Dr. Roy Laird

*Director of Bronx Mental Health Services*

*Children's Aid Society*

Andrew Malekoff

*Chief Executive Officer*

*North Shore Child and Family Guidance Center*

Dr. Ed Dana

*Executive Director,*

*Martin De Porres School*

Cathy Menzies

*Licensed Clinical Social Worker, Private Practitioner*

*Martin De Porres School*

Sharee Lewin

*School Psychologist,*

*Martin De Porres*

California Subjects

Susan Moser

*Departmental Resources Manager,*

*Los Angeles County Department of Mental Health*

Victoria White

*Director of Outpatient and Day Treatment*

*Pacific Clinics*

Weston Taussig

*Lead therapist, Private practitioner*

*Pacific Clinics*

Name Redacted\*

(Participant wishes to remain anonymous)

### Appendix 3: Interview Questions

Name:

Profession:

State/Region covered in your profession:

Approximately how many years worked in this field?

1. **Mental Health Facilities:** What services do you offer children with mental health illnesses?
2. What services do you provide for disadvantaged children?
3. **Mental Health Facilities** Does your organization get state and/or federal funding? If so, what is it?
4. **Mental Health Facilities** What type of health insurance do most of the children placed in this location have?
5. What is the state of children's mental health care? For children covered by private health insurance? For underserved children (foster kids, children covered by Medicaid)?
6. In your opinion does their insurance help them receive the treatment they need? Why or why not?
7. What impact will the Affordable Care Act have on your organization?
8. About 20% of children with mental illness receive the help that they need. Who are the children receiving the help and who aren't?
9. How will the implementation of the ACA affect child mental health care? What impact will the Affordable Care Act have on children's mental health care (statewide, locally)?
10. What are some services provided to children with mental illness by the state and/or city?
11. Are there any other services offered to those living with mental health disorders?
12. Are there any services provided through the public school system by school psychologists?
13. **Schools** Please explain the difference between mental health services privately provided for children and mental health care provided by schools. Is one better than the other?
14. **Schools** Will mental health services be provided for all schools, including private? Will all students have equal access to care?
15. **Schools** How will the implementation of the Affordable Care Act affect children's mental health services in schools?
16. Are there any existing programs that should be altered in order to improve children's mental health care?
17. What are some of the best practices to implement in order to have equity for poor children in the mental health care system? In your opinion, what practices should be implemented to improve children's mental health care? How will it be accessed and equitable?

18. **Policymakers** About how much funding is allocated for children's health care in New York State (California)? In New York City (Los Angeles)? Children's mental health care?
19. **Policymakers** Between 2009 and 2011, New York cut \$132 million (California, \$587.4 million) from their budgets allocated for mental health services for children and adults. How was this done? (i.e. was funding redirected?) Why was funding cut? Did New York (California) offer any other services to those living with mental health disorders? About how much of the funding was cut from children's mental health care?
20. **Policymakers** Do you think mental health care can be improved for children? How or in what ways would you think states would be more willing to improve policy for disadvantaged children?
21. Is there anything else you would like to add or include on this topic?
22. Is there anyone else that you think would be a useful resource for me to interview?

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