

# The Tulsa County Children's Behavioral Health Study



## *Key Findings and Recommendations*

**Tulsa County Children's Behavioral Health Study Committee**

Community Service Council of Greater Tulsa (CSC)



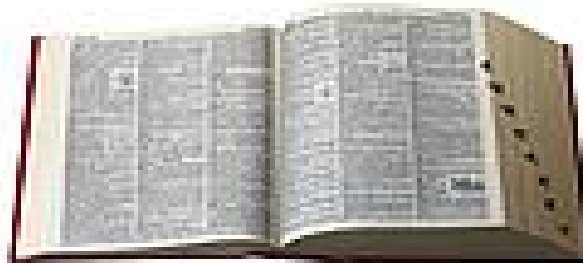
November 2005

## *Presentation Overview:*

- Definition of Emotional/Behavioral Disorder
- Purpose
- Methods of investigation
- Who are we talking about? One example
- Key findings
- Recommendations
- CSC endorsement of recommendations and next steps

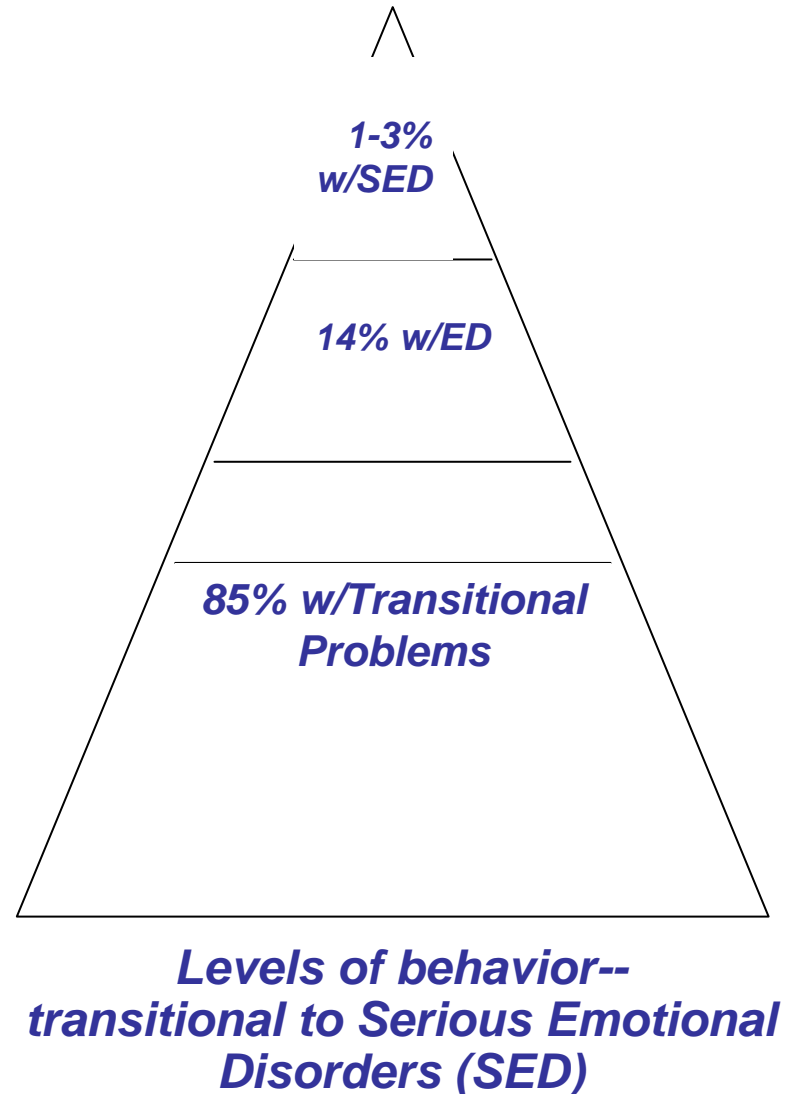


# ***What is the Definition of Emotional/Behavioral Disorder (EBD)?***



## ***Emotional Behavioral Disorder (EBD):***

Emotional or behavioral disorders (EBD) refer to conditions where a child's behavioral or emotional responses, from birth to young adulthood, and in typical environments and social settings, are so different from generally accepted, age-appropriate, ethnic, or cultural norms that they adversely affect performance and healthy development in daily life.





## ***Purpose of CSC's Children's Behavioral Health Study:***

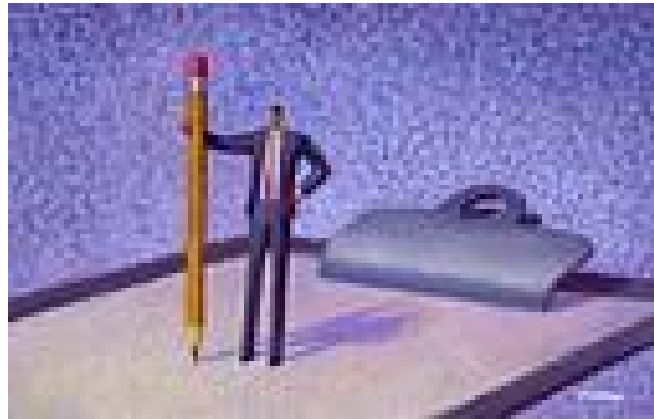
- Identify community needs, key challenges, and strengths
- Identify opportunities to build Tulsa's capacity to improve children's health and behavioral health

### **→ *Expected Study Outcomes:***

*A community assessment  
with recommended steps  
to build Tulsa's capacity  
to meet our children's  
behavioral health needs*



# ***Methods of Investigation to Guide Recommendations***



## ***Methods of Investigation:***

- Defined scope of study: children & youth, ages 0-22
- Endorsed guiding values
- Heard expert presentations
- Reviewed the literature
- Held listening sessions with stakeholders, e.g., families
- Reviewed available data—secondary data analyses

*Built on the 2002 Needs Assessment by the Mental Health Association of Tulsa (MHAT)*



## ***Methods of Investigation, continued:***

- Incorporated information from State Conference with national leaders
- Monitored information via local organizations
- Reviewed media coverage
- Explored public policy options—funding sources
- Examined best, effective and promising practices



## *Who Are We Talking About?*



**One example: meet Tom...**



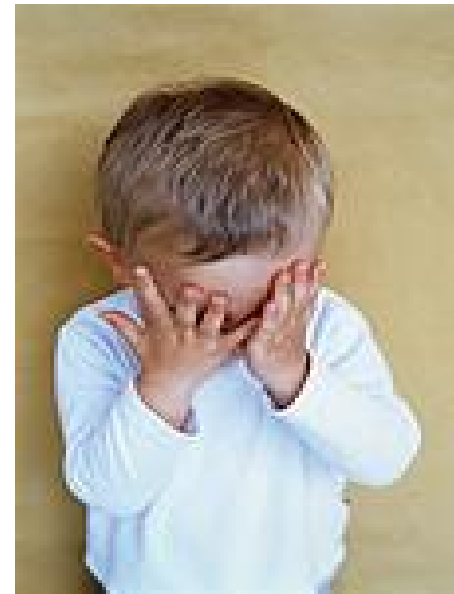
*A Tulsa public school story...  
Tom is one of five similar children  
in a local kindergarten class*

*Description: Tom, age 5,  
a new Tulsa kindergarten student*

- **Defiant** -- oppositional, sarcastic, argumentative, oblivious to others
- **Demanding** -- constantly demands to do whatever he wants
- **Violent** -- kicks, bites, hits, head-butts, throws chairs
- **Yells** -- at teachers, calls them names, cusses

## **Description — Tom, continued...**

- **Threatens** -- to kill himself; calls himself ugly; is sure nobody likes him
- **Unable to sit at group time** -- completely unfamiliar with classrooms
- **Distracts** -- constantly interrupts class time
- **Without good parenting** –
  - Dad**, under a protective order for domestic abuse
  - Mom**, remarried; on Meth; constant financial problems



# Key Findings –

## *Setting the Context for Recommendations*



## ***Key Finding #1:***

***Little investment has been made in preventing poor behavioral health outcomes for our children.***

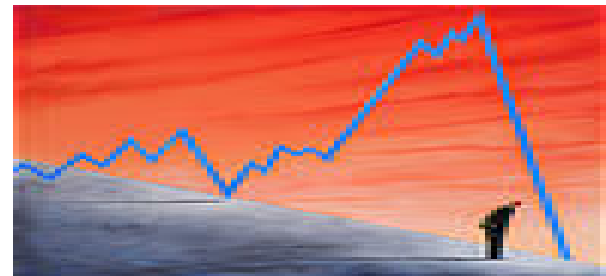
- One-fifth of our children have diagnosable mental, emotional, or behavioral disorders
- Up to 1/10 of children suffer from a serious emotional disturbance (SED)
- 70-75% of kids with a diagnosable disorder do not receive mental health services
- Children living in poverty are affected by mental health disorders at much higher and more intense levels than children in higher income populations



## ***Key Finding #2:***

### ***Significant numbers of Tulsa kids have an EBD.***

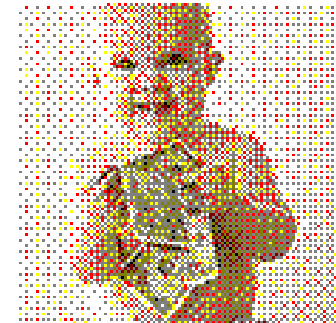
- An estimated 21,000+ (21%) Tulsa County children, <18, have an emotional disturbance (ED)
- An estimated 7,000 (within a range of 4-8%) Tulsa children experience Serious Emotional Disturbance (SED) or significant impairment in home, school, and community



## **Key Finding #3:**

### **Investment in our kids is missing the mark.**

- Mental/behavioral health dollars are rarely invested in resources *early* and for young children
- In 2002, only 23% of those in need were served (~1,500 Tulsa children with SED)
- Young adults (18-22) need wrap-around services, but cannot find them; in fact, existing “wrap around” funds are time-limited
- Estimated cost of services is higher than actual (DMH) payment, demonstrating the gap in needed resources; e.g., level of Medicaid reimbursement is insufficient, etc.



## ***Key Finding #4:***

***A good beginning + a healthy mother = good behavioral health for a child.***

- Maternal health and mental health are *both* central to a child's health and well-being
- Risks for poor child behavioral health correlate with younger, uneducated single mothers
  - 33% of births in Tulsa County are to unwed mothers
  - 77% of young mothers, < age 20, were unmarried at the time of birth



## ***Key Finding #5:***

### ***Poor parent health & behavior = poor child health & behavioral health.***

- Domestic violence is a predictor for poor behavioral health, for both the victim and the family member (child) witnessing the abuse—and Oklahoma’s rate of domestic violence for pregnant women is very high (one and a half times the national average)
- Paternal health and mental health are central to a child’s health and well-being, yet research has not been done
- Divorce impacts a child’s behavioral health; in FY2002, for every 100 marriage licenses granted, Oklahoma granted 76 divorce petitions



Parent/Family

## ***Key Finding #6:***

### ***Growing numbers of kids have challenging needs.***

- 1/5 of Tulsa children under age five live in poverty
- 1/4 of all Oklahoma children/youth live in poverty
- Poor children are at risk by >50% to develop behavioral health problems vs. others, yet less likely to access or seek help or services
- A large number of Tulsa Public Schools have an estimated 30% of students with disabilities



## ***Key Finding #6, continued:***

### ***Growing numbers of kids have challenging needs.***

- Children with dual diagnoses (EDB + disability) have poor access to assistance, expertise, and services
- Race has a higher correlation with behavioral health problems among children and youth
- 639 Tulsa children were abused or neglected in FY2003, most < age 12; last year 51 children died in Oklahoma as a result of neglect/abuse

## ***Key Finding #7:***

### ***Teens/young adults must be given the tools for self-sufficiency and adulthood.***

- A youth who enters the juvenile justice system by age 13 typically has behavioral health problems; research shows this teen is more likely to live a life of crime
- Nearly 10,000 Oklahoma students drop out of high school each year, increasing the risk of EBDs
- On any given day, over 7,000 Oklahoma children are in foster care: in Tulsa County, approximately 9%, about 550-600+ children, are in foster care
- Youth with EBD, especially foster teens, are left with few opportunities after age 18, and are increasingly landing in homeless shelters



## **Key Finding #8:**

***Tulsa's overall system is inadequate.***

**Access to early help is critical--but in Tulsa...**

- ***Early engagement opportunities are limited,*** especially for screening and effective assessments
- ***Overall resources are limited***
  - Prevention resources for behavioral health are almost non-existent in Tulsa
  - Access to services is harder for uninsured and Medicaid populations, especially in a city categorized as a “medically underserved area” (MUA)
- ***Skilled resources for complex problems are limited***
  - Tulsa needs more diverse, well-trained professionals in all fields--disabilities, education, clinical, legal, etc.
  - Even with adequate child physician numbers in Tulsa, low reimbursements deter doctors from working in behavioral health



## ***Key Finding #9:***

### ***Tulsa needs to build capacity.***

- In FY 2003 and across state agencies, Oklahoma spent nearly \$200M on child/youth behavioral health with little accountability
- Available information on children's behavioral health and accessing help is poorly organized and hard to find
- With poor access to information, Tulsans are unaware of the scope of problems resulting from poor child behavioral health
- Interest from Tulsa organizations, including family advocacy organizations, exists but lacks coordination
- Training and expertise, with cross training, is needed across disciplines



## Key Finding #10:


**There is no accountability  
to assure best practices  
in children's behavioral health**



*Only 397 Oklahoma children and youth are served by the best practice referred to as the "Systems of Care Approach"*

*Only about 123 children are in Systems of Care (SOC) in the Tulsa region (the largest site)*

## ***Best practices approaches/values:***

-  *Family centered*
- *Child centered*
- *Community-based*
- *Family therapy*
- *Case management (family advocacy)*
- *Integration with other services, e.g., the school joins the plan*
- *Innovative and culturally appropriate approaches*
- *Appropriate services in the “Least Restrictive Environment” (LRE)*
- *Individualized/tailored services, e.g., transportation, school aides, etc.*
- *Interagency coordination and agreement on one plan*

## *Summary of Key Findings*



## ***Summary of Key Findings:***

- (1) Little investment for preventing poor child behavioral health outcomes—our investment is missing the mark
- (2) A good beginning + healthy parents = good behavioral health for a child
- (3) Significant and growing numbers of Tulsa kids with EBD and relevant challenging needs
- (4) Young people must be given the tools for self-sufficiency or face increased risk for incarceration, homelessness, etc.
- (5) Tulsa's overall system is inadequate; access to early help is critical but remains limited, and expertise in all systems is hard to find

***In short -- Tulsa needs to build capacity, with accountability, for best practices in children's behavioral health***

*Where do we go from here?*



*The Study recommends  
building capacity  
in three stages*

# *Study Recommendations Include:*

## *Stage 1...*

Connect Tulsa working groups, forming one **leadership committee** to develop the “building blocks” for change to:

- **Locate funds for building local capacity**

- Est. \$450K for the next 3 years
- Find within the next 6 months

- **Identify and engage staff** to oversee committee work to build community capacity

- Locate within the next 1-7 months
- Prepare first annual work plan



## Stage 2 ...

- ***With funds and staff, establish steering and sub-committees, with responsibilities***
- ***Establish timelines*** for creating new system components
- ***Begin organizing for key system components:***
  - Early access to needed help
  - A local Information/data system
  - Local/regional social marketing
  - Blended and locally-controlled \$s
  - Research and training



***Stage 3—the long term goal  
... with a three year timeline:***

***Create the local infrastructure  
for a leadership organization  
for children's behavioral health,  
possibly a public Authority***

*... by July, 2009*



## ***Challenges include:***

- Competition with other state and local interests
- Opposition to early childhood prevention/ intervention
- Hard-to-reach families/lack of a state presence at the legislature
- Funding, funding, funding
- Finding sustained professional and volunteer leadership



## *Opportunities include:*

- Interested leadership organizations, including CSC, OUHSC, the Juvenile Bureau with an Authority, MHAT, LTCA, etc.
- Local/state funding interest, e.g., foundations, civic and state leaders
- Strong University presence and engaged faculty
- Community leaders to carry the vision
- Good partnerships, e.g., Sharelink, HealthNet, Children's Consortium
- Local research with agreement on the need
- Existing data management infrastructure, e.g., Sharelink





## ***The Community Service Council's potential response to Study recommendations...***

- Provide staffing and committed volunteers to implement the first recommended stage
- Obtain resources to implement the second stage
- Mobilize leadership and capacity for the third stage

## ***In conclusion...***

The President's Freedom Commission  
on Mental Health states,

We must adopt *“a preventive framework to [behavioral] health to provide a multi-layered approach to assist our children.”*



***Improving outcomes  
for our children simply requires  
a change in thinking ...  
a more focused and thoughtful  
investment.***

## ***CSC's research has found that...***

Because more families have not been able to fully meet their children's needs, and no one approach provides *the* answer...



***Success in Tulsa will require our unprecedented commitment, partnering with all who share our vision.***