MODULE 1 – TEN MAJOR PROPERTIES OF "WICKED" PROBLEMS
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Starting with significant property number one, we learned that problems and solutions are inextricably linked. Let's explore this with a look at the 2003 President's New Freedom Commission Subcommittee on Children and Family Policy Report. In 2003, the President's New Freedom Commission published its report entitled, "Achieving the Promise: Transforming Mental Health Care in America."

This report was informed by a series of subcommittee reports addressing specific issues in populations. The Subcommittee on Children and Family examined policy options to promote and restore children's mental health, AKA behavioral health. In addition to the subcommittee's four-part vision, it identified nine values ranging across home and community-based care, family partnerships, comprehensive supports and services, cultural competence, individualized care, evidence-based practices, services and systems coordination, early identification and intervention, and accountability.

These nine values drove 10 policy options to be addressed at both the state and federal levels. These policy options included insurance benefits, payer and funding mechanisms, interstate commerce, coverage for family support services, technical assistance, individualized care plans, screening, and the creation of numerous state plans to address interventions, financing of care, promotion and prevention, and workforce development in schools, primary care and especially provider settings, juvenile justice and child welfare settings.

With that in mind, let's take a look at the two graphics. The first graphic shows eight broad areas that comprise the child and adolescent services systems. The pie chart below it shows the percent coverage of funding by the different entities that pay for services delivery. It looks fairly simple.

However, each of these areas-- services, systems, and payers-- is affected by one or part of elements of existing legislation. We will look at three: the Affordable Care Act, Medicaid, and the Mental Health Parity and Substance Abuse Equity Act. Under the Affordable Care Act, there are opportunities to expand coverage of mental health conditions and substance use disorders, as part of the broad essential benefits package of services under the ACA.

The Mental Health Parity and Substance Abuse Equity Act also requires parity, which is equal coverage of behavioral health services as physical health services to be offered to individuals who have health insurance coverage. This implies that funding for prevention, early intervention, and treatment services and programs will also expand. Now, since Medicaid patients are affected by federal money flowing down to states for disbursement, as well as interpretations of federal law into state policy, the use of Medicaid health services carve-outs at the state level have limited the availability of public dollars for low-income children's behavioral health care.

And layered on top of that are states' efforts to move to an integrated care model, meaning no more carve-outs. Now let's look at two states, Massachusetts and Florida. In 2006, the Massachusetts Supreme Court, in its review of Rosie D. versus Romney, determined that the state Medicaid program had failed to provide the care required by the Medicaid Early and Periodic Screening, Diagnosis, and Treatment Program, the EPSTD, to children with SED.

It also found that the state programs had failed to organize community care in such a way that children with SED could be cared for at home. The solution was to amend the existing state legislation and administrative code to ensure adequate screening in home-based care. However, the discussion on how to do this is still ongoing in the state of Massachusetts.

In 2013, the Florida legislature decided not to take Medicaid expansion dollars, which would have expanded access to care to uninsured families. The Senate wanted to develop an alternative plan that would use federal dollars under the law to expand Florida to Healthy Kids, which is a health exchange for low-income children. However, the plan would need to be approved by both the House and the Senate, signed by the governor, and then approved by the federal government.

So if this plan doesn't get approval from all these players, then children and adolescents lose out. To date, this problem has not been solved. Now multiply this kind of federal/state funding scenario for each of the eight services areas on the previous slide and we start to have a glimpse of the difficulty involved in disentangling inextricably linked problems and solutions.

Significant property two suggests that although we can run out of time and money, or use the infamous "it's good enough" rationale, significant problems do not then become insignificant. Consider the consequences of running out of money. A congressional House report states that during 2013, funding for the Substance Abuse and Mental Health Services Administration, SAMHSA, was reduced by nearly a billion dollars, when adjusted for inflation and population growth.

Now consider the consequences of running out of time. The congressional sequester resulted in an additional cut of nearly 6%, and other accounting approaches resulted in a funding loss of close to 7.5% for SAMHSA and for nearly all other federal agencies serving people with, or at risk of, a behavioral health disorder. Simultaneously, states cut back funding for behavioral health care by nearly $5 billion over the last three years.

Now, behavioral health care funding may fall under general fund appropriations for state mental health agencies as well as additional funding streams controlled by other state agencies, such a state Medicaid agencies, housing authorities, or child and family authorities. And this differs state by state. With the implementation of the Affordable Care Act, and subsequent Medicaid expansion, many states made deep cuts in state funding to local mental health agencies in anticipation of new federal revenues.

We're going to look at the examples of Michigan, California, Illinois, and Florida. Take the case of Michigan, which is reeling under a perpetual budget crisis. From 2008 to 2011, the Detroit Wayne

County Community Mental Health Agency, which funds a variety of city, county, and community mental health programs, took almost $13 million in cuts.

These cuts resulted in the loss of a number of home and community based care services, and the staff to provide these services. In California, the governor suspended the mandate on counties to provide behavioral health services for special education students. Counties then shifted the cost of providing and paying for the care of special education services from the county to the school systems.

However, the school systems had also had their budget slashed by the legislature. So special education services being paid for by the school systems were also reduced. Illinois cut $187 million from its mental health budget in recent years, which resulted in the closing of three of the state's nine psychiatric hospitals. Cook County Sheriff Tom Dart accused the state of using the justice system as a place to dump people with serious behavioral health problems. Florida,

which ranks 50th out of 50 in per capita behavioral health spending, also uses law enforcement and corrections as the entry into the behavioral health system. Juvenile and adult inmates are stabilized, medicated, gotten back on a regular regimen of care, and then discharged into the community. However, as community mental health programs and court diversion programs are defunded, children, adolescents, and adults with mental illnesses show back up into juvenile detention centers, jails, and prisons. For persons who have co-occurring mental illnesses and substance use disorders, the [INAUDIBLE] rate is incredibly high. As these examples show, none of these problems have become insignificant, even though time and money have run out.

Dr. Hansen, remind us again where Florida ranks.

50th out of 50, at the bottom of the list. Significant property three warns us to be cautious about how do we know when a policy change is fully implemented to meet the intent of the legislation or regulation. Oftentimes, we don't have objective criteria to show that specific benchmarks were met. Or, to further complicate the matter, there are numerous objectives due to multiple reporting lines based upon funding streams.

Building upon developing benchmarks and outcomes, who determines what benchmarks or outcomes are good? Just about any interest group has a presence in Washington, and spends money to maintain that presence. From lobbyists to political action committees, or PACs, to professional associations and organizations, to advocacy groups to lawmakers themselves, everyone is trying to influence policy to achieve their specific goals.

And contributing to the problem is the use of ambiguous language, such as "review and strengthen federal and state requirements for family participation." Who defines family participation, its scope, specifics as to how we will know family participation when we see it? Who establishes the criteria for federal and state laws so that we meet this particular review and strengthen federal and state requirements, and the corresponding administrative codes for implementation?

Let's take a moment to look at the outcomes of the Children's Mental Health and Substance Abuse Program in the state of Florida. The Children's Mental Health and Substance Abuse Program is funded by federal substance abuse prevention treatment block grants, other federal grants, state general revenue, and state and federal Medicaid resources. The substance abuse prevention and treatment block grant currently funds approximately 50% of substance abuse services. This is important, because funders have different measures to assess how well a state or program is performing.

The state of Florida long-range plan estimates there are 32,355 children in need of substance abuse services. Of these 330 plus children, 109,677, would seek services if services were available. However, the state reports only serving an average of 53,000 children per year through individualized services. To know how well Florida is doing is based upon benchmarks of care, which are federally funded dollars. So we need to review policy reports on the provision of substance abuse services and long-term outcomes of the children, which are provided by the behavioral health managing entities.

We also need to review the state's biennial substance abuse and mental health services plan, which lists the dashboard performance measures, up in the upper right hand corner. Dashboard data is reported monthly, and details the levels of performance for each region, each circuit, and each service provider which then details the levels of performance for each region, each circuit, and each service provider.

In addition, the behavioral health epidemiology workforce, which collects and analyzes public health, criminal justice, and other indicators, also has its annual state/county level report to show how well Florida is doing. The Department of Children and Families, known as DCF, also uses the Substance Abuse and Mental Health Information System, SAMHIS, to collect, maintain, analyze, and report data on persons served in state-funded mental health treatment facilities and state-contracted community substance abuse and mental health provider agencies. The SAMHIS application integrates the sociodemographic and clinical data regarding persons served with the data regarding provider sites, programs, performance targets, and outcomes.

Continuing on, Florida is also using the National Outcome Measures, the NOMs, that are used in performance-based programs that are funded by the Substance Abuse and Mental Health block grants, and performance measures mandated in the federal General Appropriations Act. Centered on ten domains, the receipt of federal funding is contingent upon reporting these measures.

In addition, DCF also conducts a number of stakeholder meetings and surveys to determine customer satisfaction in other program areas to make adjustments and improvements to services delivery. This information is required by federal mandate to be used in assessing provider quality of care. In addition, all performance-based state agencies and contractor agencies are reviewed by the Office of Program Policy Analysis and Government Accountability, also known as OPPAGA.

So, after wading through all these reports, indicators, and other measures, what can we conclude? In fiscal year 2013 to 2012, the latest data, 70% of the children in Florida who could substance use disorders completed substance abuse treatment. Is this a good outcome?

Our answer-- it depends on what else you want to measure. We don't know if children improved academic achievement, if they stayed out of the juvenile justice system, if they have a stable home life, or other measures. So again, is this a good outcome? What it is that you want to measure is an important question to ask.

Significant property number four, waves of consequences is reinforced by Sigmund, a communications scholar who reminds us of the consequentiality of communication. That is, what things people do during social interactions have an impact on the lives, the institutions in which they work or use, and the relationships they establish. Consequentiality of communication has material and political legal consequences in behavioral health services.

Whether the focus is on populations or services, accurate representation of that population or those services is essential. Polysemy is the capacity for a word or a phrase to have many possible meanings. What these words or phrases mean can signify practice. That is, position a population or a service in such a way that it becomes the preferred population, preferred service, or preferred practice, perhaps to the detriment of a larger group.

An example is the difference between using the phrases "family-centered care" and "wraparound services." Both types of care focus on the child and family as the focus of service provision. Both work with children who have special needs.

Wraparound, however, has been designated a promising practice by the federal government. Family-centered care has not. Who is funded? Wraparound services. So what is said and how it is framed is important, particularly when we are looking at provision and delivery of care.

Significant property number five warns us there is no such thing as a do-over, that every attempt counts. One-shot operations, when the solution has to be now, abound in public policy making, where immediate action is seen as a hasty resolution to an identified problem. However, one-shot operations have an amazingly high failure rate.

For behavioral health services in particular, it is risky to assume that a "one size fits all" approach will work. A specific one-shot operation was the emergence of wilderness therapy camps, boot camps and academies-- also known as boarding schools-- for boys and girls who had a variety of addiction, behavioral, and emotional problems. In 2007, the Government Accountability Office, the GAO, published a report on these residential treatment programs.

The GAO examined thousands of allegations of abuse, some of which involved death at these residential treatment programs during the years 1990 to 2007. It examined hundreds of thousands of documents and closed cases, including police reports, autopsy reports, and state agency

oversight reviews, as well as investigations recorded by state agencies and the Department of Health and Human Services, in addition to allegations detailed in pending civil and criminal trials with hundreds of plaintiffs.

During 2005 alone, 33 states reported 1,619 staff members were involved in incidents of abuse in residential programs. The 2007 report also examined in detail 10 closed civil or criminal cases where an adolescent died while enrolled in a private program. The GAO found significant evidence of ineffective management in most of these 10 cases, with program leaders neglecting the needs of program participants and staff.

However, as [INAUDIBLE] property five, reminds us, there is no such thing as a do-over. Hence the need for reflection in defining the problem, examining possible solutions, and choosing the best option based upon the evidence presented. Significant problem six tells us that significant problems do not have an exhaustively describable set of potential solutions. There is never criteria to tell us that all solutions have been identified and considered.

So how many solutions you put forward to solve a problem? Let's look again at the subcommittee's policy options and start a discussion on the financing of care, specifically the need to expand health insurance. Possible solutions include, as we can see in the list on the right, expand coverage, re-define eligibility, define an essential benefits package, on and on and on.

So before we go too far, let's get to the bottom of the current list and say support the use of empirically-supported prevention and early intervention strategies as one possible solution. So in the best public policy making and policy analysis process, we convene an expert panel. And the expert panel comes up with the following list of things that need to happen to resolve the question of how the behavioral health system supports the use of empirically-supported prevention and early intervention strategies.

Here's how that conversation may go. Panelist one: we need access to effective, empirically-supported practices, with a specific focus on-- name your population. Panelist two: we need to convene another expert panel to determine best practices. And we also need a study group to examine the effects of implementing these practices within the state of the nation.

Expert panelist number three: each practice will be examined as to fidelity of implementation. Panelist four: a meta-analysis of methodologies within those studies will be conducted. Panelist five: studies that meet similar criteria will then undergo a comparative effectiveness review. Panelist six: recommendations will be made that include review of impact on state budgets, requirements of federal funding, and match programs.

Panelist number seven: these practices will be adopted statewide. Panelist eight: performance outcomes will be determined. Look at an example of Hawaii's Orange Book. Panelist nine: well, the Orange Book is based upon the blue menu of evidence-based child and adolescent psychosocial

interventions, which is based on the evidence-based performance matrix from the American Academy of Child and Adolescent Psychiatrists.

Panelist 10: Well, these practices should be incorporated into our state's evidence-based services committee biannual report, and the state mental health plan. And for each of these solutions, there are more solutions that could still become about and still not find all the possible solutions, because someone inevitably would find another solution or another item to place on the list. Significant property seven reminds us that every significant problem is essentially unique. Despite similarities between previous problems and current ones, each has a one of a kind quality, much like zebras and snowflakes.

Take the example of care coordination across multi-sectoral provider systems, which is a recurrent issue of the provision of child and adolescent behavioral health services. Care coordination typically involves managing multiple services across medical and behavioral health services, social services, and other community supports. Although there is no consistent definition of care coordination, the National Quality Forum defines care coordination as a function that helps ensure the patient's needs and preferences for health services and information-sharing across people, functions and sites are met over time.

When we look at pediatric care coordination, Antonelli et al. define that as a patient and family-centered, assessment-driven, team-based activity that stresses optimal outcomes for children and their families by addressing interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes. However you define care coordination, the continuity of care for children and adolescents with complex behavioral and medical health needs has been identified as a central issue in the provision of services across multi-sectoral provider systems.

So if we take a look at how care is delivered and paid for by an insurance provider, we come to a topic near and dear to Dr. Levin's heart. First we had the primary care physician. He or she would diagnose and refer the patient out if there was a behavioral health diagnosis. This is under fee for service care, a payment model where services are unbundled and paid for separately.

In primary health care, physicians received a fee for each service provided, whether it was a lab test, an office visit, a referral, or a telephone consultation. This was eventually seen as a less than desirable option in funding care, so reimbursement was based on quantity rather than quality of care. So say goodbye to fee for service, and say hello to managed health care and managed behavioral health care.

Managed health care looks at bundled payments, episode of service payments, and capitation, a set amount for each enrolled person assigned to them per period of time, whether that person seeks care or not. Managed care spawned carve-outs, also known as specialty care. Carving out mental health benefits and capitated managed behavioral health care was seen as an easier way for payers, who saw the de facto behavioral health care system as too costly to develop and maintain.

So carve-out vendors emerged who were them accredited by national organizations. The vendors then credentialed and assembled networks of providers who used behavioral health professionals to provide utilization and case management, again, all for a known, per member, per month fee. In Florida, pulling back for a moment for a more specific view, we had for over a decade the Children's Prepaid Mental Health Plan, in which children enrolled under a managed behavioral health care plan had so much allotted per member, per month for services.

Now in 2014, we are moving back into an integrated care plan under the Sunshine State Health Plan, where behavioral health care is provided across a continuum of care, coordinated across independent behavioral health and primary health care providers to shared facility use. As you can see on the table, where we have coordinated, minimal collaboration all the way to a completely integrated system where you are co-located in the same facility.

So the issue under investigation is the success of implementing an integrated care approach, which is different from current funding and reimbursement mechanisms but is still the same, because how do we pay for care? And how do we ensure that everyone who needs care receives the appropriate care and is able to be in an insurance system where they can afford to get care?

Let's examine significant property eight, where every significant problem can be considered to be a symptom of yet another problem. The problem: in 2014, a total of 13 entire Florida counties were designated a primary medical care health professional shortage area. 62 of 67 counties in Florida who were designated a mental health health professional shortage area.

The solution? Clearly, we need to hire and retain more physicians and a lot more behavioral health professionals to work in the state of Florida. Well, from that problem, there's another problem. Children, particularly those in the child welfare system, have disproportionately high rates of health problems, with up to 87% of the children having some form or combination of physical, developmental, or mental health disorders.

So in addition to having to hire more behavioral health professionals, we need to also look at increasing intensive case management in child services sectors. Well, if we're looking at children and child welfare, if we look at the adolescents in the United States, DSM-5 disorders appear to be highly prevalent and more persistent among adolescents than among adults, with prevalence estimates of any DSM-4 disorder at more than 40% during a 12 month period, which looks to be estimated at about 79.5% of lifetime cases.

So we need better and more intensive adolescent mental health services overall in addition to intensive case management service in child services sectors in addition to hiring more behavioral health specialists. But we have another problem. Data from the National Survey on Child and Adolescent Well-Being show that after investigation for maltreatment, 50% of teenagers in the study reported at least one developmental health problem, 28% reported at least two mental health problems, and almost 20% reported three or more problems.

So we really need to overhaul the national child welfare systems, as well as the national behavioral health care system. But now we're looking at the problem when the age of onset for approximately half of all lifetime mental disorders is when a child is in his or her mid-teenaged years. The percentage increases to 75%. so we need to have more access to prevention, intervention, and utilization behavioral health services to reach more children.

And as those kids transition out of foster care, we have another problem. Foster-age youth, 17 to 18 and older, are two to four times more likely to suffer from lifetime and/or past mental health disorders, compared to transition-aged youth in the general population. So we really need to provide better continuity of care across systems. But wait a minute. Here's another problem.

Persons with chronic mental illnesses have higher rates of chronic physical illnesses. Further, chronic physical and mental illnesses together are known to increase the risk of premature death, and certainly increased morbidity among adolescents and adults. So we need to reduce the incidence of the co-occurring disorders in children and adolescents with earlier and more frequent screening, diagnosis, treatment, and maintenance.

But you know, the problem is, it's estimated that, in the United States at least, at least one out of every four to five children will experience a mental health problem over the course of their lifetime. Well, that's an easy solution. We need to build an integrated, effective, coordinated care system for children and adolescents with behavioral health disorders, because behavioral health, as we know, incorporates mental illnesses, substance use disorders, and developmental disabilities.

So you can see how we start from relatively small problem, the lack of providers for behavioral health services in a state. We steadily start to see how each identified problem requires another solution, and how each solution is part of a larger solution, until we reach the relatively simple solution, which is creating an effective, integrated, coordinated system of care to deal with behavioral and physical health disorders for children and adolescents that seamlessly allows them to transfer into an equally effective, integrated, coordinated system of care for adults with behavioral and physical health disorders.

Moving on to significant property number nine, which suggests there is no rule to determine the correct explanation of a problem. [? Hegem, ?] who is a major policy researcher, reminds us that the paradox of the policy process is indeed itself. The words and ideas used by the world of policy simultaneously describe and define both policy problems and solutions.

We also have the issue of perspectives. Perspectives tend to be pragmatically or theoretically oriented. The pragmatic significance often addresses real life terms, such as allocation of resources, or the larger social well-being of an identified group or community. The theoretical significances focus more on the anticipated insights of an area for the public policymaking process in general.

More often than not, whether you take a pragmatic or a theoretical perspective, the problem will be reframed into manageable bits. And it's really how these bits are framed and named and made sense of that concerns us most in the policymaking process. Otherwise, we are lost in the proverbial black box of policymaking, the institutional void.

How is a problem identified? What criteria are used? What arguments are put forth to substantiate the claim that x is indeed a problem? Who decides what is evidence? Who is the expert? Whose voice or voices are heard? Who acts? Who or what is the agent for change?

These are some of the questions that we will actually explore this semester. In normal or routine policy changes, there's really no significant shift in the balance of power or the redistribution of resources. Routine policy change is the tacit reinforcement of an existing understanding of a socially constructed issue, event, or action. The institutional discourse may not change significantly.

And any change that is made will be consistent with present understandings of how things are. Second order policy change, however, identifies and involves the development of new policy instruments and strategic actions. Second order policy change has the potential to solve and identify a social problem. It alters power and resources, revises fundamental rules and processes of social systems.

However, second order policy change requires us to have a change in how we understand things, how all of us at the table understand a particular issue or solution. For second order change to occur, it's really best that individuals are suspicious, cautious of certain directional changes, and take the time to examine them carefully to determine whether core concepts and actions still make sense.

And this is not an easy thing to do. When you're taking a macro-level view of value systems, legislation, regulatory requirements, organizational structure, cultural practices or research availability, in many cases we get lost in the forest and fail to see the trees. Or we can see the tree, but not see the forest.

I want to take a moment to clarify a term that I used when I talk about the social construction of an issue. A social construction of an issue is when we as individuals or as a group or as institution say, this is the way we define or frame this particular issue or problem. So in many cases, when I'm talking about social policy or when we are talking about re-framing policy, we may be using social policy as a phrase, but we are looking at societal policy overall, of which there are different elements that can be broken out into health policy, specifically into behavioral health policy, specifically into substance abuse policy, et cetera.

So when we were talking about the whole notion of social construction, and this is about voices and languages of stakeholders, we bring these notions, these social constructions that we hold true, or as the way the world is framed, to the table. And so when we are talking about creating policy or agreeing, coming to consensus of how a policy should be enacted, these are some of the major

issues that we must contend with at the table or in the bill writing or in the regulation, development, and in, also, outcomes and measurement so that we come out with a policy that benefits societally to the good.

Coming into the home stretch, which I believe is a sports term that Dr. Levin would appreciate, in the case of [INAUDIBLE] property number five, where there is no opportunity to learn by trial and error-- every attempt counts, also known as there is no do-over property-- significant property number 10 admonishes us that the consequences of actions, matter, and responsibility have to be taken.

So let's take a look back at the residential treatment facilities investigation by the GAO. In all, the GAO investigated allegations in 49 states that reported investigating complaints of youth maltreatment in residential facilities, which included physical abuse, neglect, and sexual abuse. 28 states also reported deaths. What did the GAO find? There were six main findings.

First, it found that there were no standard definitions for specific types of programs. So there was no standard definition that defined the scope of a wilderness therapy program, a boot camp, or a boarding school. This is problematic. Some types of facilities were exempt from state licensing requirements, primarily the state-operated juvenile justice facilities and private residential schools and academies.

In addition, lack of state oversight meant that states did not know if the license program deviated from the terms of the licenses. So once the death of a child occurred, states then took action against programs that did not follow the state health and safety guidelines. States differed widely in how they licensed and monitored the types of programs in terms of the agencies and requirements involved.

The GAO also found that although there were national and federal standards for residential facilities, including those licensed by licensing boards, state level the national quality programs such as the Joint Commission on Insurance Companies and federal government agencies such as TRICARE and Center for Mental Health Services, there were no federal laws that defined and regulated residential treatment programs.

Only the Departments of Health and Human Services, Education and Justice had reporting requirements for those facilities, but not across all the elements that addressed abuse and neglect prevention, suicide prevention, use of seclusion and restraint, and education quality. And even their scope as federal agencies was limited to private or public programs supported by federal funds.

So federal agencies were therefore unable to hold states accountable for conditions in facilities that were exclusively private. So the GAOs concluded that facilities were often reckless and negligent in their operating practices. They employed untrained staff who could not determine legitimate medical emergencies, and children died or became seriously ill.

The tough love approach and other approaches that these programs used resulted in injury, near death, and in some cases suicide by the children who were in these facilities. So bottom line, the GAO concluded that state and federal oversight gaps increased youth risk, well-being at residential treatment facilities. However, this was a multi-year investigation with hundreds of thousands of hours invested to come to these conclusions.

And at the end of the day, due to a poorly-conceived intervention and implementation and lack of appropriate definition and oversight, thousands of children were abused and there were avoidable deaths. So after these conclusions and these reports, who was responsible? How would you consider parsing out responsibility? How would you fix this problem? A report of this size and of this magnitude--

[SAD HORN]

How does this get fixed?