# National Survey of State Children's Mental Health Directors: Current Status and Future Directions

**Mario Hernandez, PhD**
**Mary Armstrong, PhD**
**Amy L. Green, PhD**
**Melissa H. Johnson, MA, MPH**

## Abstract

*State agencies play a critical role in addressing the mental health needs of children and youth. Significant changes underway throughout the nation at the federal and state levels have led to questions about the role of state children's mental health (CMH) agencies and the effects of these changes on children's services. The purpose of this study was to examine the current status of state offices for CMH with regard to structure and responsibilities and to identify what state CMH directors express as opportunities and challenges for CMH at the state level. CMH directors or their representatives from 46 states, 1 US territory, and D.C. completed an online survey developed to address the specific aims of this study. Findings highlight the importance of a strong state structure to support CMH and opportunities for reform and system change, particularly related to the Affordable Care Act and expansion of Systems of Care.*

National epidemiological data suggest that approximately one half of youth in the USA experience a diagnosable mental disorder at some time in their lives.[1] Further, there is evidence that approximately half of all lifetime cases of mental disorders begin by age 14.[2] Despite these rates, it has been estimated that between 50% and 70% of children with mental health needs do not receive services.[3, 4] Currently, there are significant changes underway at the federal level and in states

Address correspondence to Mario Hernandez, PhD, Department of Child and Family Studies, College of Behavioral and Community Sciences, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, FL 33612, USA. Email: marioh@usf.edu.

Mary Armstrong, PhD, Department of Child and Family Studies, College of Behavioral and Community Sciences, University of South Florida, Tampa, FL, USA.

Amy L. Green, PhD, Department of Child and Family Studies, College of Behavioral and Community Sciences, University of South Florida, Tampa, FL, USA.

Melissa H. Johnson, MA, MPH, Department of Child and Family Studies, College of Behavioral and Community Sciences, University of South Florida, Tampa, FL, USA.

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regarding the provision of child and adolescent behavioral health services, most notably, the ramifications faced by states as they implement the Patient Protection and Affordable Care Act (ACA).[5–7] In particular, the ACA builds on the Mental Health Parity and Addiction Equity Act,[8] advancing coverage for mental health and substance abuse services and prompting attention to mental health promotion, prevention, and access to evidence-based care.[9, 10] Even within this context of reform, however, current state laws mandating or regulating mental health benefits vary widely.[11] At the time of the current study, for example, 29 states (including the District of Columbia) were participating in Medicaid expansion, 6 states were undecided, and 16 states were not participating.[12]

New opportunities created by the ACA for prevention, care coordination, and integration of behavioral health with primary care present opportunities for growing the capacity of child mental health systems to meet the needs of children and adolescents. Capitalizing on these opportunities depends upon a well-developed and coherent services delivery system[13] and the input of state leaders knowledgeable about child and adolescent behavioral health.[14, 15] The structure of state offices for children's mental health and the role of the leaders in those offices is critical to understand if these opportunities are to be realized. Knowing how state leaders for children's behavioral health services are involved in state level policy and planning discussions and whether these leaders have roles that can influence policy and funding is important to the positive growth and evolution of behavioral health services for children and adolescents.

Thirty years ago, in a groundbreaking report, *Unclaimed Children*, Knitzer and Olson demonstrated that the public mental health system in the USA was neglecting the needs of children with mental health disorders and their families.[16] Among the findings were the following: two out of three youth with serious mental health problems did not receive any services; few state departments of mental health were actively working toward developing and implementing community-based programs; little attention was paid to early intervention and prevention; very few states were engaged in creating coordination between agencies serving children; and fewer than half of states had a children's unit within their mental health departments. Notably, states that did have organizational units for children tended to be more knowledgeable about funds available for child and adolescent services, and more likely to work toward the development of child-specific standards for mental health programs. A number of recommendations came out of this report that focused on improving state policy and planning for children and youth with mental health needs and their families. In particular, to increase the mental health policy focus on children, it was recommended that administrative units for child and adolescent mental health services be established within states and be staffed by professionals with the capacity and authority for leadership.[16] This recommendation is echoed by implementation science, which emphasizes the importance of developing organization and systems components to support new practice, as well as the necessity of addressing complex implementation challenges through appropriate leadership strategies.[17]

In a follow-up to Knitzer and Olson's 1982 study, *Unclaimed Children Revisited* by Cooper and colleagues was completed in 2008.[18] This updated study found that some progress had been made in the promotion of evidence-based practices, responsiveness to family and youth voice, and the delivery of culturally and linguistically competent services. However, many challenges were still found to exist. Findings from this report demonstrated that there are groups of children and youth that states struggle to serve appropriately, particularly children with co-occurring disorders, developmental disabilities, or substance abuse problems. Findings also suggested deficiencies in the development of state infrastructures to adequately support child and adolescent behavioral health services. Findings further demonstrated that states were challenged in having adequate funds for services, lacked strategies for building the workforce, and were not fully addressing cross-system collaboration.

The challenges identified in 1982 and again in 2008 identify a state-level need to have structures and leaders within those structures able to advocate and plan for meeting the unmet demand for

child and adolescent behavioral health services. Clearly, the current context of behavioral health requires strong leadership at the state level to address these pressing needs.

In following the trajectory of children's mental health over time, the purpose of this study was to examine the current status of state-level children's mental health offices and the role of state leaders in those offices. Of particular interest was how these state offices are structured and how the structure relates to other state offices. The role of state leaders in terms of their authority and influence, and the responsibilities these leaders are assigned in relationship to those structures was also examined. Finally, the study also sought to identify the challenges and opportunities that are perceived by state directors for children's mental health.

## Methods

A survey of state children's mental health directors was developed for the current study to: (1) assess the status of state-level children's mental health, including organizational and system structures, capacities, and sociopolitical contextual factors that impact services, and (2) examine the current role of state children's mental health directors in three areas: policy and planning, services and supports, and workforce. The survey was developed through an iterative process in which initial items were developed by study team members and then feedback was obtained from a small sample of state-level children's mental health personnel. The goal of engaging state-level children's mental health personnel in the development of the survey was to identify a set of questions that have relevance, despite the fact that states vary widely in how policies and practices are administered. The resulting 17-item online survey included a combination of closed- and open-ended questions and was administered through *Qualtrics*, a Web-based survey program. See Table 1 for a list of questions included in the survey.

### Survey administration

Children's mental health directors for all 50 states, 1 US territory, and the District of Columbia were identified by the roster for the Children, Youth and Families Division of the National Association of State Mental Health Program Directors (NASMHPD) and invited to complete the survey. Emails describing the purpose of the survey and inviting participation were sent through *Qualtrics*. Directors who were unable to be reached via email were contacted by phone and given the option to complete the survey by phone. While the majority of directors completed the survey online, two directors asked to complete the survey by phone and one completed the survey by hand and emailed it directly to the research staff. If the individual listed on the NASMHPD roster was unavailable to complete the survey or felt that they were not suited to complete a survey regarding children's mental health in their state, research staff identified the most appropriate individual to complete the survey. The survey was administered between September 2013 and March 2014.

### Sample characteristics of participating states

Children's mental health directors or their representatives from 46 states, 1 US territory, and the District of Columbia completed the survey (total $n = 48$). For purposes of brevity and anonymity, all participants are hereafter referred to as "states." In order to maintain anonymity of findings, participating states were categorized into four regions (northeast, midwest, south, and west) according to the classification system used by the NASMHPD (see Table 2 for the NASMHPD classification system). Table 3 provides the child population, median income, percentage of poverty, and race/ethnicity for each region based on data obtained from the Annie E. Casey Foundation's Kids Count Data Center.[19] As can be seen from this table, there is some degree of variability between regions based on these demographic characteristics.

**Table 1**
Survey questions

**Closed-ended questions**
- Are you the point of authority for children's mental health (yes/no)?
- Is children's mental health a separate unit/entity in your state (yes/no)?
- Does your state agency also include the following (check all that apply—adult mental health; adolescent substance abuse; child welfare; juvenile justice; health; Medicaid; other)?
- If you had to measure how much of your current primary role uses "authority" vs. "influence," what percentage would you rate for each over the course of the last year (0–100%)?
- Are there individuals and/or organizations outside of government in your state who advocate for children with mental health needs and their families (yes/no)?
- Please indicate on the following scale how influential these individuals/groups are collectively to your state (little to no influence/slight influence/moderate influence/highly influential).

**Open-ended questions**
- What state agency do you work in?
- How many staff members are in your unit?
- How many staff members do you supervise?
- What are the opportunities that you foresee for children's mental health in the next 5 years?
- What are the challenges that you encounter regarding the status and role of children's mental health?
- Please identify any other concerns about the status and role of children's mental health currently and into the next 5 years.

**Closed-ended questions followed by open-ended questions**
- Is children's mental health partly merged with another unit/entity in your state (yes/no)? If yes, please describe.
- For each of the areas listed, please indicate if you have authority, influence, both authority and influence, shared (with another person(s) or entity(ies)), or neither. For each area where you indicated shared, please explain.
- Do you have budget control over children's mental health (yes/no)? If yes, describe your role in relation to managing Medicaid dollars for children's mental health services.
- Do you have authority over a portion of block grant funds (yes/no)? If yes, please advise what percentage and explain your authority.
- If you have local regions, do they have authority (yes/no)? If yes, please describe.
- Is your state planning for implementation of the Affordable Care Act (yes/no)? If yes, please describe your projected role in this implementation.
- Do the individuals and/or organizations you identified who advocate for children with mental health needs and their families support you in your position (yes/no)? If yes, please describe the ways in which they are helpful to you. If no, please describe the ways in which they are not helpful to you.


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## Analysis

Survey data were obtained from *Qualtrics* and descriptive analyses were conducted for closed-ended survey items using IBM SPSS v.22 statistical analysis software. Data from closed-ended survey items were analyzed overall (including all states) and also by region. To maintain a broad

**Table 2**
States and territories invited to complete the survey

| Northeast | Midwest | South | West |
|---|---|---|---|
| Connecticut | Illinois | Alabama | Alaska |
| Delaware | Indiana | Arkansas | Arizona |
| District of Columbia | Iowa | Florida | California |
| Maine | Kansas | Georgia | Colorado |
| Maryland | Michigan | Kentucky | Guam |
| Massachusetts | Minnesota | Louisiana | Hawaii |
| New Hampshire | Missouri | Mississippi | Idaho |
| New Jersey | Nebraska | North Carolina | Montana |
| New York | North Dakota | Puerto Rico | Nevada |
| Pennsylvania | Ohio | South Carolina | New Mexico |
| Rhode Island | Oklahoma | Tennessee | Oregon |
| Vermont | South Dakota | Texas | Utah |
| | Wisconsin | Virginia | Washington |
| | | West Virginia | Wyoming |

States and territories are listed by region according to the National Association of State Mental Health Program Directors (NASMHPD; http://www.nasmhpd.org/)

view of directors' responses, data obtained from the open-ended survey questions were analyzed overall (including all states) using Atlas.ti v.6.2. Open coding was used to identify key themes and concepts that emerged from responses to the open-ended survey questions,[20] resulting in an initial list of 16 codes. These codes were then analyzed in terms of their relation to each other in order to identify sets of codes that touched on similar or related topics. This process was reiterated until a final set of four overarching code families emerged that organized all of the participants' responses: Service Structure, Organizational and System Capacity, SocioPolitical Environment, and Reform and System Change. Both opportunities and challenges for children's mental health systems were identified within these codes.

## Results

Findings from both the open- and closed-ended survey questions are presented in the following sections by code family (i.e., Service Structure, Organizational and System Capacity, SocioPolitical Environment, and Reform and System Change). In instances where closed-ended survey questions were followed by specific open-ended survey questions, findings from related questions are presented together. See Table 1 for a list of survey questions.

### Structure of state children's mental health systems

In this section, findings related to the organizational structure of children's mental health units, the role of state children's mental health directors, and implications that the current system structure has for the delivery of children's services are presented. For purposes of the current study, "structure" is defined as the overarching framework by which the agency is organized and encompasses the lines of authority, communications, and the ways in which roles and responsibilities are assigned, controlled, and coordinated. Structure also provides the foundation for the agency's policies, operating procedures, and decision-making processes.

**Table 3**
Description of states within each region

| | Northeast ($n=12$) | Midwest ($n=12$) | South ($n=13$) | West ($n=11$) |
|---|---|---|---|---|
| Child population[a] | 1,147,335.5 | 1,177,199.5 | 1,982,290.46 | 1,530,182.27 |
| Median income[b] | 71,891.67 | 61,116.67 | 51,566.67 | 61,009.09 |
| Percent poverty[c] | 18.08 | 19.25 | 28.77 | 19.36 |
| Percent NH white[d] | 62.09 | 70.34 | 55.22 | 58.39 |
| Percent NH black[e] | 15.98 | 8.47 | 24.96 | 3.39 |
| Percent NH other[f] | 8.16 | 10.07 | 6.01 | 16.23 |
| Percent Hispanic[g] | 13.76 | 11.12 | 13.81 | 21.99 |

[a]Average child population in 2012
[b]Median income among households with children in 2012
[c]Percentage of children in poverty in 2012
[d]Percentage of non-Hispanic White alone children in 2012
[e]Percentage of non-Hispanic Black alone children in 2012
[f]Percentage of non-Hispanic other children in 2012 (includes non-Hispanic American Indian, Alaskan Native, Asian, Native Hawaiian, other Pacific Islander, and two or more race groups)
[g]Percentage of Hispanic or Latino children in 2012

### *Organizational structure of children's mental health*

When asked if children's mental health is a separate unit/entity in their agency, just over half of all directors (56%, $n=27$) said yes. Responses to this question varied by region, whereby children's mental health was reported to be a separate unit/entity in the majority of states from the northeast and west regions, but in less than half of states from the midwest and south regions. When asked if children's mental health is partly merged with another unit/entity in their state agency, less than one third of all directors (31%, $n=15$) said yes. Responses to this question also varied by region, whereby children's mental health was reported to be partly merged with another unit/entity in 46% ($n=5$) of states from the west region, 33% ($n=4$) of states from the northeast region, 31% ($n=4$) of states from the south region, and 17% ($n=2$) of states from the midwest region. It is important to note that because these questions were asked independently, it was possible for directors to indicate that children's mental health is a separate unit/entity in their state agency and that it is partly merged with another unit/entity within the state (yes/yes responses); this was the case for 10% ($n=5$) of states. Out of the 48 states, directors from 11 states (23%) reported children's mental health is neither a separate unit/entity in their state nor is it partly merged with another unit/entity in their state agency (no/no responses).

In a related question, directors were asked to indicate if their agency also included any of the following entities: adult mental health, adolescent substance abuse, adult substance abuse, child welfare, juvenile justice, health, Medicaid, intellectual/developmental disabilities, or other. As shown in Table 4, overall, the majority of directors indicated that their state agency included the following three entities: adult mental health, adolescent substance abuse, and adult substance abuse. All of the states in the midwest and south regions reported their state agency also included adult mental health, and more than 90% of states in these two regions reported their state agencies also include adolescent substance abuse and adult substance abuse. Overall, less than half of directors indicated that their state agency included Medicaid, child welfare, or juvenile justice, health, intellectual/developmental disabilities, or some other entity (see Table 4).

For 42% ($n=20$) of participating states, directors indicated there are local geographic entities that have authority over child mental health. Based on geographic region, directors reported that

**Table 4**

Number and percentage of CMH units overall and within each region that include additional units/entities

| | Adult mental health | Adolescent substance abuse | Adult substance abuse | Medicaid | Child welfare | Juvenile justice | Health | Intellectual/ developmental disabilities | Other |
|---|---|---|---|---|---|---|---|---|---|
| Overall ($n=48$) | 40 (83%) | 37 (77%) | 33 (69%) | 18 (38%) | 17 (35%) | 12 (25%) | 9 (19%) | 5 (10%) | 5 (10%) |
| Northeast ($n=12$) | 7 (58%) | 5 (42%) | 2 (17%) | 4 (33%) | 6 (50%) | 4 (33%) | 1 (8%) | 0 (0.0%) | 1 (8%) |
| Midwest ($n=12$) | 12 (100%) | 11 (92%) | 11 (98%) | 7 (58%) | 4 (33%) | 1 (8%) | 2 (17%) | 1 (8%) | 0 (0%) |
| South ($n=13$) | 13 (100%) | 12 (92%) | 12 (92%) | 3 (23%) | 1 (8%) | 2 (15%) | 2 (15%) | 4 (31%) | 1 (8%) |
| West ($n=11$) | 8 (73%) | 9 (82%) | 8 (73%) | 4 (36%) | 6 (55%) | 5 (46%) | 4 (36%) | 0 (0%) | 3 (27%) |

62% ($n = 8$) of states from the south region, 42% ($n = 5$) of states from the midwest region, 36% ($n = 4$) of states from the west region, and 25% ($n = 3$) of states from the northeast region had local geographic entities with authority over child mental health. As described by directors, a local geographic entity was identified as either organized by counties or by a larger regional district. Directors also reported that these regions have considerable variability in terms of the responsibilities and requirements placed on them. It was typically stated that local entities have a contract with the state child mental health authority to provide mental and behavioral health services. In some states, contracts with local authorities specify a set of basic required services that these entities must, at a minimum, provide. The local entities may then provide additional services based on identified local needs. On the other hand, some states indicated that their local contracts do not include any specification as to how services are to be delivered or what services must be provided, leaving these decisions open to the local entities to determine.

### *Role of state children's mental health directors*

When asked if they are the point of authority for children's mental health in their state, almost all directors replied yes (92%, $n = 44$), and there was little variation in this self-identification in the percentage among states from the different regions. As the point of authority for children's mental health, directors were asked to indicate the degree to which they have authority/influence over the different activities in their role. In two separate questions, directors were asked to report: (1) what percentage of their current role uses authority (0% to 100%), and (2) what percentage of their current role uses influence (0% to 100%). Because these were separate, independent questions, the percentage of authority and percentage of influence reported by directors does not necessarily equal 100%. "Authority" was defined in the survey as a power or right delegated or given; a person or body of persons in whom authority is vested, as a governmental agency. "Influence" was defined as the capacity or power of persons to be a compelling force on or produce effects on the actions, behavior, and opinions of others.

Overall, there was a wide range of responses to these questions, with directors reporting that anywhere between 25% and 100% of their current role uses influence and anywhere between 3% and 100% of their current role uses authority. The overall trend for all regions was for directors to report that a greater percentage of their role uses influence than authority. Directors from the northeast region reported that, on average, 76% of their current role uses influence, but only 45% of their current role uses authority. Similarly, directors from the midwest region reported than on average 60% of their current role uses influence, but only 40% of their current role uses authority. Directors from the south region reported that, on average, 71% of their current role uses influence, while only 42% of their current role uses authority. Finally, directors from the West region reported that, on average, 68% of their current role uses influence and 36% of their current role uses authority.

To better describe the reported proportions of overall authority versus influence in their roles, directors were asked to indicate their level of authority and influence in three areas: policy and planning; services and support; and workforce. For each of these areas, directors were asked to indicate if they had: only authority, only influence, both authority and influence, shared authority/influence, or neither authority nor influence in these three areas. Findings for each of these areas are as follows.

*Policy and planning* The area of policy and planning includes the following categories: strategic planning, policy development, enforcement and accountability, interagency collaboration, and media and public education. For most topics in this area, directors most often reported having both authority and influence. However, while they may be the point of authority for children's mental health, directors most often reported that they shared authority/influence for enforcement/accountability and media/public education with another person or entity. These were also the

**Table 5**

State children's mental health director's roles in the area of policy and planning

| Region | Topic | Authority only | Influence only | Authority and influence | Shared authority/influence | Neither |
|---|---|---|---|---|---|---|
| Overall | Strategic planning | 5 (11%) | 11 (23%) | 18 (38%) | 13 (28%) | 0 (0%) |
| $N=47$ | Policy development | 10 (21%) | 10 (21%) | 16 (34%) | 11 (23%) | 0 (0%) |
| | Enforcement/accountability | 6 (13%) | 10 (21%) | 13 (28%) | 15 (32%) | 3 (6%) |
| | Interagency collaboration | 4 (9%) | 15 (32%) | 18 (38%) | 10 (21%) | 0 (0%) |
| | Media/public education | 2 (4%) | 13 (28%) | 10 (21%) | 15 (32%) | 7 (15%) |
| Northeast | Strategic planning | 0 (0%) | 1 (9%) | 8 (73%) | 2 (18%) | 0 (0%) |
| $n=11$ | Policy development | 2 (18%) | 2 (18)% | 6 (55%) | 1 (9%) | 0 (0%) |
| | Enforcement/accountability | 0 (0%) | 0 (0%) | 7 (64%) | 4 (36%) | 0 (0%) |
| | Interagency collaboration | 0 (0%) | 3 (27)% | 8 (73%) | 0 (0%) | 0 (0%) |
| | Media/public education | 1 (9%) | 1 (9%) | 4 (36%) | 3 (27)% | 2 (18)% |
| Midwest | Strategic planning | 3 (25%) | 2 (17%) | 2 (17%) | 5 (42%) | 0 (0%) |
| $n=12$ | Policy development | 3 (25%) | 3 (25%) | 1 (8%) | 5 (42%) | 0 (0%) |
| | Enforcement/accountability | 3 (25%) | 2 (17%) | 0 (0%) | 6 (50%) | 1 (8%) |
| | Interagency collaboration | 1 (8%) | 4 (33%) | 3 (25%) | 4 (33%) | 0 (0%) |
| | Media/public education | 1 (8%) | 3 (25%) | 2 (17%) | 5 (42%) | 1 (8%) |
| South | Strategic planning | 1 (8%) | 5 (39%) | 5 (39%) | 2 (15%) | 0 (0%) |
| $n=13$ | Policy development | 2 (15%) | 4 (31%) | 4 (31%) | 3 (23%) | 0 (0%) |
| | Enforcement/accountability | 0 (0%) | 6 (46%) | 3 (23%) | 4 (31%) | 0 (0%) |
| | Interagency collaboration | 2 (15%) | 4 (31%) | 3 (23%) | 4 (31%) | 0 (0%) |
| | Media/public education | 0 (0%) | 5 (39%) | 2 (15%) | 5 (39%) | 1 (8%) |
| West | Strategic planning | 1 (9%) | 3 (27%) | 3 (27%) | 4 (36%) | 0 (0%) |
| $n=11$ | Policy development | 3 (27%) | 1 (9%) | 5 (46%) | 2 (18%) | 0 (0%) |
| | Enforcement/accountability | 3 (27%) | 2 (18%) | 3 (27%) | 1 (9%) | 2 (18%) |
| | Interagency collaboration | 1 (9%) | 4 (36%) | 4 (36%) | 2 (18%) | 0 (0%) |
| | Media/public education | 0 (0%) | 4 (36%) | 2 (18%) | 2 (18%) | 3 (27%) |

only topics for which any directors reported having neither authority nor influence. There were no notable trends by region; see Table 5 for detailed information overall and by region.

*Services and support* The area of services and support includes the following topics: treatment services, prevention and early intervention, and support services. Overall, across all topics in this area, directors least often reported having authority only. For treatment services, most directors reported having either influence only or having both authority and influence. For prevention/early intervention, however, directors were most likely to report having only influence or having shared authority/influence with another person or entity. For support services, the majority of directors reported having either only influence, both authority and influence, or shared authority/influence. Across categories in this area, between 6% and 15% of directors reported they had neither authority nor influence, and there was a slight trend whereby the greatest frequency of "neither" responses was for support services. By geographic region, the highest percentage of shared authority/influence was observed for the south and midwest regions. Additionally, it was only in the south region that no directors reported having authority only for any of the topics on this area. See Table 6 for detailed information overall and by region.

*Workforce* The area of workforce includes the following categories: quality assurance, licensure, standard setting, best practice guidelines, and technical assistance. Overall, across all categories in this area, directors least often reported having authority only. Among all topics in this area, licensure was the topic for which directors most frequently reported having neither authority nor influence. Additionally, for the topic of licensure, directors were more likely to endorse having only influence than they were to endorse having only authority or both authority and influence. There were no notable trends by region; see Table 7 for detailed information overall and by region.

### *Budget control and block grant funds*

With regard to budget control, less than half of directors overall (46%, $n = 22$) reported that they have budget control over children's mental health. Directors from 55% ($n = 6$) of states in the west region, 50% ($n = 6$) of states in the northeast region, 42% ($n = 5$) of states in the midwest region, and 39% ($n = 5$) of states in the south region reported having budget control over children's mental health. As a follow-up question, directors who reported having budget control over children's mental health were asked to describe their role in relation to managing Medicaid dollars for children's mental health services. Of the 19 directors who responded to this follow-up question, most (74%, $n = 14$) reported that they do not have authority over Medicaid dollars, although some described having influence or some degree of oversight or advisory role over how Medicaid funds are spent. Of those who did indicate involvement in the management of Medicaid funds, roles that were reported included development and implementation of Medicaid-funded services, monitoring, and quality assurance.

With regard to block grant funds, more than half of directors overall (58%, $n = 28$) reported that they have authority over a portion of block grant funds. Block Grant funds provide funds and technical assistance to all 50 states, the District of Columbia, Puerto Rico, the US Virgin Islands, and six Pacific jurisdictions. Grantees use the funds to provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system.[21] Across all regions, 64% ($n = 7$) of directors from the west region, 58% ($n = 7$) of directors from the northeast region, 58% ($n = 7$) of directors from the midwest region, and 54% ($n = 7$) of directors from the south region reported having authority over a portion of block grant funds.

As a follow-up question, directors who reported having authority over a portion of block grant funds were asked to describe what percentage they had authority over and explain their authority. Responses to this question suggest that the amount of block grant funding allocated to children's services is highly variable across states. Directors reporting that they have authority over a portion

**Table 6**

State children's mental health directors' roles in the area of services and support

| Region | Topic | Authority only | Influence only | Authority and influence | Shared authority/influence | Neither |
|---|---|---|---|---|---|---|
| Overall | Treatment services | 4 (9%) | 13 (28%) | 18 (38%) | 9 (19%) | 3 (6%) |
| $n=47$ | Prevention/early intervention | 3 (6%) | 17 (36%) | 6 (13%) | 16 (34%) | 5 (11%) |
| | Support services | 5 (11%) | 12 (26%) | 11 (23%) | 12 (26%) | 7 (15%) |
| Northeast | Treatment services | 1 (9%) | 2 (18%) | 7 (64%) | 1 (9%) | 0 (0%) |
| $n=11$ | Prevention/early intervention | 1 (9%) | 4 (36%) | 2 (18)% | 4 (36%) | 0 (0%) |
| | Support services | 1 (9%) | 1 (9%) | 6 (55%) | 2 (18)% | 1 (9%) |
| Midwest | Treatment services | 2 (17%) | 4 (33%) | 3 (25%) | 2 (17%) | 1 (8%) |
| $n=12$ | Prevention/early intervention | 2 (17%) | 5 (42%) | 1 (8%) | 3 (25%) | 1 (8%) |
| | Support services | 2 (17%) | 4 (33%) | 1 (8%) | 4 (33%) | 1 (8%) |
| South | Treatment services | 0 (0%) | 5 (39%) | 3 (23%) | 4 (31%) | 1 (8%) |
| $n=13$ | Prevention/early intervention | 0 (0%) | 5 (39%) | 2 (15%) | 4 (31%) | 2 (15%) |
| | Support services | 0 (0%) | 4 (31%) | 1 (8%) | 6 (46%) | 2 (15%) |
| West | Treatment services | 1 (9%) | 2 (18%) | 5 (46%) | 2 (18%) | 1 (9%) |
| $n=11$ | Prevention/early intervention | 0 (0%) | 3 (27%) | 1 (9%) | 5 (46%) | 2 (18%) |
| | Support services | 2 (18%) | 3 (27%) | 3 (27%) | 0 (0%) | 3 (27%) |

**Table 7**

State children's mental health directors' roles in the area of workforce

| Region | Topic | Authority only | Influence only | Authority and influence | Shared authority/influence | Neither |
|---|---|---|---|---|---|---|
| Overall | Quality assurance | 4 (9%) | 12 (26%) | 11 (23%) | 17 (36%) | 3 (6%) |
| $n=47$ | Licensure | 3 (6%) | 16 (34%) | 5 (11%) | 6 (13%) | 17 (36%) |
| | Standard setting | 5 (11%) | 14 (30%) | 10 (21%) | 16 (34%) | 2 (4%) |
| | Best practice guidelines | 6 (13%) | 12 (26%) | 17 (36%) | 11 (23%) | 1 (2%) |
| | Technical assistance | 9 (19%) | 9 (19%) | 20 (43%) | 9 (19%) | 0 (0%) |
| Northeast | Quality assurance | 0 (0%) | 2 (18%) | 4 (36%) | 5 (46%) | 0 (0%) |
| $n=11$ | Licensure | 0 (0%) | 6 (55%) | 1 (9%) | 0 (0%) | 4 (36%) |
| | Standard setting | 0 (0%) | 2 (18%) | 4 (36%) | 5 (46%) | 0 (0%) |
| | Best practice guidelines | 2 (18%) | 2 (18%) | 6 (55%) | 1 (9%) | 0 (0%) |
| | Technical assistance | 2 (18%) | 0 (0.0%) | 6 (55%) | 3 (27%) | 0 (0%) |
| Midwest | Quality assurance | 3 (25%) | 2 (17%) | 1 (8%) | 3 (25%) | 3 (25%) |
| $n=12$ | Licensure | 1 (8%) | 2 (17%) | 1 (8%) | 2 (17%) | 6 (50%) |
| | Standard setting | 2 (17%) | 3 (25%) | 1 (8%) | 6 (50%) | 0 (0%) |
| | Best practice guidelines | 2 (17%) | 2 (17%) | 2 (17%) | 6 (50%) | 0 (0%) |
| | Technical assistance | 2 (17%) | 3 (25%) | 5 (42%) | 2 (17%) | 0 (0%) |
| South | Quality assurance | 0 (0%) | 6 (46%) | 3 (23%) | 4 (31%) | 0 (0%) |
| $n=13$ | Licensure | 1 (8%) | 6 (46%) | 1 (8%) | 3 (23%) | 2 (15%) |
| | Standard setting | 1 (8%) | 7 (54%) | 2 (15%) | 3 (23%) | 0 (0%) |
| | Best practice guidelines | 1 (8%) | 5 (39%) | 4 (31%) | 3 (23%) | 0 (0%) |
| | Technical assistance | 2 (15%) | 3 (23%) | 5 (39%) | 3 (23%) | 0 (0%) |
| West | Quality assurance | 1 (9%) | 2 (18%) | 3 (27%) | 5 (46%) | 0 (0%) |
| $n=11$ | Licensure | 1 (9%) | 2 (18%) | 2 (18%) | 1 (9%) | 5 (46%) |
| | Standard setting | 2 (18%) | 2 (18%) | 3 (27%) | 2 (18%) | 2 (18%) |
| | Best practice guidelines | 1 (9%) | 3 (27%) | 5 (46%) | 1 (9%) | 1 (9%) |
| | Technical assistance | 3 (27%) | 3 (27%) | 4 (36%) | 1 (9%) | 0 (0%) |

of block grant funds indicated that the children's portion of the block grant in their states ranges from 20% to 50% of their state's total block grant allocation, and most directors indicated that they had authority over the full amount that is allocated to children. Their role in managing the block grant funds includes allocation of funds to local authorities and providers, determining what services and activities can be supported with the funds, and monitoring and ensuring compliance in the use of funds. In addition, at least seven directors described their role as having influence or advising about the use of funds, not authority over the funds within their states.

### *Challenges with the current structure*

A concern expressed by directors is the lack of priority given to children's mental health services within the current system structure. One issue is the fact that children's mental health services are typically not stand-alone entities, but are one of many entities within their state agency, often sharing funding with or even falling under the authority of other programs. As one respondent described, for example, "[There] seems to be some evidence that children's mental health is disappearing into Medicaid offices or with adult services, which essentially can gobble them up without good leadership." A number of directors described children's mental health services as an "afterthought" or as a subordinate to other programs or departments where they are housed, especially with regard to adult mental health services. Over 80% of directors reported that their agency included adult mental health. Directors described the consequences of this, including a lack of attention, accountability, and funding given to children's mental health services compared to adult services: "Most attention is given to the adult system, which has more money and consumers. This results in the children's system waving the flag not to forget the children's system of care." Funding for early intervention, furthermore, was expressed by some as a challenge. One director elaborated that, "Despite work to identify and intervene early, we still struggle to demonstrate that resources need to go to kids. We know that early childhood, social/emotional development, and trauma are important, but it is difficult to get money for prevention—this is a real barrier." Some suggestions were that there should be national standards for children's mental health to which states are held accountable, and that funding streams, such as the Block Grant, should have a section specifically for children to prevent unfair distribution.

In addition to inadequate funds and unequal allocation of resources, the current structure also creates concern that the unique needs of children will be ignored. One respondent, for example, explained that, "The state makes changes to children's and adult mental health programs at the same time, and it is difficult to make sure that policy makers understand the different needs in children's services." Another added, "Funding of children's mental health is based on an adult Medicaid service delivery model, which at times stifles creativity and where services can occur."

## Organizational and system capacity

In this section, findings related to organization and system capacity are presented. For purposes of the current study, organizational and system capacity concerns the ability of state agencies to provide adequate and appropriate services to meet community needs, and to monitor and ensure the quality of providers and services. This includes maintaining adequate workforce capacity, ensuring appropriate training and licensing procedures for providers, and collection and use of data for quality management, monitoring outcomes, and continuous quality improvement. Directors identified key issues with regard to current workforce capacity, the accessibility and availability of children's mental health services, and data system capacity.

### *Workforce capacity*

Children's mental health directors identified several challenges with the capacity of their current workforce, which include a lack of highly qualified providers, overall workforce shortages, and insufficient state-supported training and technical assistance to the workforce. The lack of qualified mental health providers, such as licensed clinicians and child psychiatrists, was a concern reported by several directors: "We have a growing need, but workforce quantity and skill is not keeping up with the demand." In some cases, licensed providers may be available but are unwilling to work with the state's Medicaid and uninsured populations. Additionally, directors felt that the available workforce is inadequately trained and prepared to work within the demands of a public mental health system. For example, there was a reported perception that not all professional schools prepare the workforce to work in the public sector or adequately teach the use of evidence-based practices. Directors expressed views that the overall lack of funding for children's mental health services that many states face presents a further challenge to ensuring sufficient workforce capacity. Without sufficient financing or opportunities for career advancement, it is difficult to keep qualified workers in the public sector. Directors identified that funding for training and certification is limited and this makes it difficult for state agencies to provide ongoing professional development to the workforce. Some directors expressed that they have little in place as far as provider standards or oversight of standards if they exist. The limitations and challenges in workforce capacity have negative implications for the quality of care that is provided to children and their families.

Some state directors, however, did describe foreseeable opportunities for workforce development. At least two directors anticipated expanding the availability of training opportunities in their states, and one respondent identified implementation of standardized mental health assessment statewide as a key step toward improving care.

### *Accessibility and availability of services*

Many directors described the lack of or limited access and availability to services as another significant challenge for their states. As already reported, the availability of a qualified workforce is scarce; as a consequence, availability of an array of services and treatment options is also a challenge. In addition to a limited service array in many states, discrepancies in insurance coverage for mental health services create further restrictions in access. It was noted that interestingly, Medicaid-eligible families tend to have access to a broader array of children's mental health services and supports than privately insured families, as the following responses note:

> Children's mental health is very unequally provided between the Medicaid population and those who are commercially insured. Ironically, the Medicaid population seems to have a much more robust system of care and scope of services. There needs to be better standards applied to all population groups.
>
> There is both a perception and a reality of an access differential for commercially insured youth versus those covered by Medicaid; too many people believe that services are not available to the general population.

Overall, directors expressed that while it is encouraging that Medicaid covers a variety of mental health services and supports resulting in care that is more accessible to the most economically disadvantaged children and families, it is unfortunate that many private health insurance providers do not cover such a variety of services and supports. As a result, the out-of-pocket costs associated with obtaining services are prohibitive to many families in need. Given the limited funding for children's mental health services that many states directors identified, ensuring access to care for all children with mental health needs is a challenge. Overall, it was unclear from the responses whether state directors play any role in determining private insurance benefits. One director suggested that "we must find a way to blend the public sector and private sector."

### *Data and quality assurance systems*

Having the infrastructure in place to monitor practice, consistently measure outcomes, and use data for informed decision-making processes is a critical organizational capacity to support quality assurance and continuous quality improvement. The lack of practice standards and outcome indicators, at both the state and national levels, were expressed as a concern for children's mental health agencies. Several directors expressed concern about their data capacity and described insufficient state data infrastructures as one of their greatest challenges. This included limited capacity for states to collect outcome data and to track services provided. Further identified was the lack of data available to state agencies to demonstrate the effectiveness of the services being provided and to identify areas for practice improvement. As one respondent noted, the absence of infrastructure and useful information "makes the 'sell' of children's mental health to legislative bodies and others a challenge." Without data to demonstrate that services are both effective and cost-efficient, children's mental health agencies will struggle to advocate for continued support and funding. As one director described, there is a need for children's mental health "to be more deliberate in 'proof of concept.' We need to enhance our ability to use data to justify the direction of the field." A number of directors indicated an interest and need to improve the collection and use of outcomes data.

## Sociopolitical environment of children's mental health

In this section, findings related to the sociopolitical environment are presented. For purposes of the current study, the sociopolitical environment refers to social, cultural, and political processes, at local, state, or national levels, that affect the availability and provision of services. These processes may include political and community support or opposition, priorities, and dominant attitudes and beliefs with regard to mental illness and mental health services. Directors identified three aspects of the sociopolitical environment that they perceive as having a significant impact on children's mental health services: interagency collaboration and coordination, child and family advocacy groups, and social stigma toward mental health problems and treatment.

### *Interagency collaboration and coordination*

Children's mental health systems often involve interactions across multiple child-serving agencies. Many directors noted that these interagency relationships are often quite challenging because they require agencies that tend to "operate in silos" to share authority and responsibility for child and family outcomes. As one respondent described, "the mental health system is not one system; we are multiple systems with different values and practices. Any time a system is so diffuse, there are challenges in providing continuity of care and rallying behind the same values." Respondents stated that the current climate of health reform has created further impetus for interagency collaboration, but this has also brought to light the depth of change that is required: "The challenge is bringing together agencies who have traditionally worked in isolation. This is requiring more than building relationships; it is requiring cultural change within agencies." Many directors reported that balancing diverse interests and sharing authority across multiple agencies with no single authority for children's mental health is one of the greatest challenges to providing effective services for children and families. The need to "knock down silos" was a recurrent theme across these responses.

The identified challenges to collaborate and coordinate across agencies were counter-balanced by expressed opportunities to improve interagency relations. Several explicit opportunities were identified for increased collaboration through initiatives that are currently underway in some states. For example, one respondent indicated that their state was "actively working to make structural changes in all our child-serving agencies. Exciting collaborations as well as organizational changes to make us more functional to meet the needs of the children we serve." Another respondent described the tremendous

amount of support they have received from a cabinet Secretary "who has gone as far as to ask for a realignment or redesign of children's behavioral health services across all child-serving agencies in her cabinet, including partnership with those child-serving agencies outside of our cabinet." Examples of specific collaborative efforts provided by directors included partnerships with juvenile justice, child welfare, and schools. Increasingly, federal grant opportunities are emphasizing interagency partnerships, providing states with strategic opportunities to develop and enhance the infrastructure needed to support effective collaboration and coordination efforts.

### *Child and family advocacy*

Directors from all states reported that there are individuals or organizations in their state who advocate for children with mental health needs and their families. When asked how influential these individuals/groups are in their state, the majority of directors (85%, $n = 41$) reported that they were moderately to highly influential. The vast majority of directors (93.8%, $n = 45$) further indicated that these individuals/organizations support them in their positions. Directors identified five key areas in which child and family advocates provide support. First, they indicated that an important role for advocates is in lobbying for policy, legislation, funding, and programs, and that many of these groups are very influential in this arena. Second, directors described advocates as helping them with the identification of community needs, and giving voice to children and families that are the recipients of services. Third, directors stated that advocate groups provide assistance to families in accessing services, and help in identifying ways in which the state can increase access. Fourth, it was reported that they often serve on children's mental health committees and advisory groups, and participate in strategic planning processes with the state agencies. Finally, directors reported that advocates provide training (e.g., for peer mentoring and parent support partners) and public education to increase promotion and awareness of children's mental health issues. Overall, directors indicated that they view child and family advocates as their partners, and described relationships of mutual respect, collaboration, and team work.

### *Stigma and lack of public awareness*

Several directors identified stigma as an ongoing challenge in children's mental health: "The stigma of mental illness is still alive and well. Children with mental health needs are strongly affected by it." Directors expressed concern that the "shame and responsibility felt by parents" often prevents early identification and treatment, as parents may be hesitant to seek out needed services. The overall lack of public understanding with regard to mental health issues can impact services in a variety of ways, including funding and availability of services, where and how services are provided, and when and how families initiate services. Finding strategies to combat and overcome stigma as well as increase public awareness and understanding of mental health, therefore, was identified by directors as critical to increasing access to needed services for families and their children.

## Reform and system change

Opportunities and initiatives for reform in children's mental health emerged as another key theme in the data. Directors identified a number of opportunities available to state children's mental health agencies, either through the ACA or other state and national initiatives, such as Systems of Care (SOC),[22, 23] to improve the service system for children and their families. However, they also noted some of the challenges inherent to implementing systems change, including the impact that leadership changes can have on the sustainability of such efforts: "It is imperative that at the same

time we are working through change that we are mindful of sustainability—both of the changes and the support."

### *Implementation of the ACA as an opportunity for reform*

Five key themes emerged from directors' responses regarding the ACA, including: planning, access/availability, services integration, early intervention/prevention, and associated challenges.

*Planning* Across all states, 67% ($n = 32$) of directors reported their state is planning for implementation of the ACA. Directors from all of the states in the northeast region (100%, $n = 12$) and directors from the majority of states in the west region (91%, $n = 10$) reported their state is planning for implementation of the ACA. In the midwest and south regions, more than one third of directors (42% and 39%, respectively) reported their state is planning for implementation of the ACA.

Of the 32 directors who reported that their state is planning to implement the ACA, was a reported uncertainty regarding their role in the implementation. Some directors ($n = 5$) explicitly reported having no role or a very minimal role in its implementation, with some individuals expressing concern that children's mental health has been overlooked in ACA planning and implementation. Those who did report having a role in the implementation described participation in strategic planning or advising and providing consultation (for example, to Medicaid) regarding aspects of ACA. In addition, a number of directors reported having a role in the development of specific services or programs that will be implemented under ACA, most notably the implementation of Behavioral Health Homes.

*Access/availability* A large majority of directors (81%, $n = 39$) perceived significant opportunities to increase the accessibility and availability of services through current expansion and reform initiatives, including ACA. There are two important impacts that ACA is expected to have for children's mental health according to directors: (1) expansion of Medicaid eligibility, and (2) inclusion of mental health services as an Essential Health Benefit (EHB) on private insurance plans. The EHB will significantly increase the number of families that have access to insurance-covered mental health services. Furthermore, directors expressed an expectation that there will be an increase in the array of services that are covered and available through commercial insurance plans. Directors particularly emphasized expanding the array of home, school, and community-based services. Several directors indicated that their state will be looking into adding new services to their Medicaid plan. Examples of ways states hope to expand services include implementation of behavioral health homes, funding family and youth Peer Support Partners, and increased placement of behavioral health services and professionals within schools.

*Services integration* Another important opportunity that directors perceived related to ACA is for greater integration of behavioral health with primary care. Several different strategies for integration were identified, including training of primary care physicians on identification of behavioral health issues and placement of behavioral health consultants within pediatric offices. Directors expressed that increased integration has the potential to increase access to mental health services for children and their families, including earlier identification of needs and better coordination of care. Several directors noted that the pediatric community has been open to this collaboration. The inclusion of mental health services as an essential health benefit has provided great impetus for this integration. As one individual described, "There is a great opportunity for children's mental health needs to be met with very little difficulty because their needs will be added to the physical health needs and the system will provide the needed services." In addition, directors envision mental health screening and assessment becoming increasingly integrated into well child visits within primary care settings.

*Early intervention and prevention* A shift in the focus of children's mental health toward early intervention and primary prevention was another area where directors hoped to see changes occur.

Directors expressed concern over the current lack of prevention and promotion in children's mental health, and felt that future efforts need to focus on public education about the importance of early intervention with children to prevent the need for high end services later on in the child's life. Some felt, furthermore, that the promotion of early intervention needs to come from the Federal government, as expressed in the following narrative from one director:

> I'm concerned that the Federal government is not doing enough to support early intervention in children's mental health, such as childhood mental health consultation which focuses on positive social and emotional development. It's a prevention model versus a treatment based model. More can be done in supporting the public health approach in children's mental health by the Federal government.

As this response illustrates, directors feel that the emphasis needs to shift from a treatment-focused approach to a more primary prevention focused approach used in public health models. This is a critical transition for children's mental health and directors perceived an opportunity through the implementation of ACA to facilitate this change. One director noted, for example, "With the increased focus on reducing healthcare costs, the increased awareness of intervening early through prevention and early intervention becomes more prevalent. These efforts are more invigorating."

*Challenges* While many directors expressed hope about anticipated reform, directors also identified impending challenges with the passing of the ACA. In some states, there is considerable cultural and political resistance to ACA, and some directors expressed concern about the impact such resistance could have on implementation. In addition, the timing of implementation is an area of concern. As one respondent noted, "There will be many lessons learned, and time will be needed to sort through the challenges that arise." Directors expressed that the roll out of ACA is occurring very quickly, but the legislation will require significant time to achieve full implementation. Furthermore, it is noteworthy that not all states are planning to implement ACA, and this concern was also expressed by some directors.

### *Expanding systems of care and evidence-based practices*

Directors reported that there has been and continues to be great focus on expanding the implementation of evidence-based practices and approaches in the provision of children's mental health services. The availability of System of Care Expansion and Sustainability Cooperative Agreements through the Substance Abuse and Mental Health Administration (SAMHSA) has been an important impetus for creating sustainable systems change in the way children's mental health services are designed and provided. A number of directors reported that their states have a current System of Care grant and are focusing on expanding implementation of the wraparound model. Several also noted that there is extensive support for the System of Care philosophy coming from their state's legislators and administration, including support from governors and state Medicaid agencies. The core values of the System of Care philosophy specify that systems are family driven and youth-guided, community-based, and culturally and linguistically competent.[22] Not all directors, however, have encountered such positive reception; some reported that the mental health providers in their states have been resistant toward change and are adamant in their interest to keep the current service structure intact. In the words of one respondent, "Individuals that are stuck in their old ways of thinking and serving is the biggest challenge."

In addition to System of Care implementation, there was interest expressed by directors in increasing the availability and utilization of other evidence-based practices for children and families, especially if there is the potential to realize cost savings. One of the most significant challenges in achieving this, it was noted, is ensuring that practices are implemented with fidelity. Achieving fidelity reportedly continues to be an issue that providers struggle with, and this is another reason why state agencies need to further develop their capacity for quality assurance and practice monitoring.

## Discussion

The purpose of this study was to examine the current status of state offices for children's mental health in the USA in order to identify how these offices are structured and what responsibilities are associated with those structures, as well as understand the authority and influence related to those responsibilities. The study also sought to identify what state children's mental health directors express as opportunities and challenges for children's mental health at the state level.

### Structure of state children's mental health

Since Knitzer and Olson's *Unclaimed Children* and the more recent *Unclaimed Children Revisited*,[16, 18] the importance of leadership in state children's mental health (CMH) has been identified. Leadership in CMH should be anchored in knowledge regarding children's behavioral health, current trends, opportunities, and issues experienced by children and their families. Because services and supports in children's mental health necessitate integration across agencies, there is a need for a clear voice from someone who understands CMH issues and can facilitate this integration. Such leadership is not possible in the absence of state structures that support the role of children's mental health directors. For this reason, understanding the manner in which child offices are structured and organized within a state is important.

This study found that a little over half of state children's mental health agencies are structured as separate entities within their states, with some variation across regions. State child offices were most commonly paired with adult mental health, adolescent substance abuse, or adult substance abuse. As expected, less than half of state directors reported that their structure included offices of Medicaid, child welfare, juvenile justice, health, or intellectual/developmental disabilities.

### State CMH directors' roles and responsibilities

Just as the presence of a state entity structure for CMH is important, within that structure, the roles and responsibilities of CMH directors are also important. While more than 90% of CMH directors reported that they themselves are the point of authority for CMH in their state, findings from this study demonstrate that directors reported using influence more than authority as a method for representing the interests of CMH in their state. Moreover, in carrying out their roles related to three key areas (i.e., policy and planning, services and support, and workforce), directors across all regions most often reported having a combination of authority and influence or sharing authority and influence with another entity within their state. Collectively, these findings point to the limited authority and complex nature of the roles and responsibilities of state CMH directors. These factors can serve to dilute the structure of state CMH. Without information from other state offices, it is difficult to interpret whether this finding is similar to how other state agencies or offices function. Additional research is needed to better understand the authority held by state level directors of children's mental health and explore potential solutions to the apparent lack of authority inherent in these positions.

Apart from the roles and responsibilities of state directors in those three areas of functioning, the current study also sought to understand the authority and influence of state directors related to budgets. Findings indicate that less than half of directors reported budget control over state CMH funds. Also noted was that state budget authority was reported highest for directors from states in the west region. Directors were also asked about their authority over state block grant funds. While there was a lot of variability across states regarding the total proportion of funding from block grants allocated to children (20–50%), most directors reported having authority over whatever that proportion was for their state. Given the authority over block grant funds reported by state CMH directors, it becomes important to advocate for an increase in the proportion block grant funds allocated to children within states. Not surprising, most directors reported having no authority over

Medicaid funds; many described having "some influence" or serving in an "advisory role" related to Medicaid funds. This minimal role of CMH in this area is important in light of the expansion of Medicaid in many states and the fact that 27 million children under the age of 18 in the USA are covered for behavioral health services through the Medicaid program.[24, 25]

*Advocacy* Advocacy efforts, particularly those of youth and families, have played a critical role in shaping the services delivery system for children's mental health. Not only have advocacy efforts spurred changes in practice and policy, but changes resulting from the efforts of family advocacy groups have contributed to an environment that is more responsive to family preferences and supportive of family and youth-driven change.[26] Directors acknowledged the important role that child and family advocacy groups play and reported that they value these groups as collaborative partners who provide valuable support and input as they carry out their roles and responsibilities. However, as expressed by the CMH directors in this study, having higher levels of state authority also value input from these groups continues to be a challenge. This observation offers some insight into results from other studies that have demonstrated a disconnect between the reported family engagement efforts of state agencies and the general dissatisfaction of advocates with the role of the family and youth voice in policy.[27] An opportunity exists to increase states' understanding of how to best engage families and youth in not only receiving services, but in advocacy efforts as well.

## Opportunities and challenges in state children's mental health

Directors identified a variety of opportunities in CMH, many of which fell within different aspects of the ACA, such as coverage for behavioral health services and a focus on prevention, and within opportunities around the expansion of Systems of Care. Interestingly, many of the opportunities identified by directors were also identified as challenges.

*Implementation of the ACA* Directors identified multiple opportunities for children's mental health within the context of implementation of the ACA. Overall, 32 directors reported that their state is planning for implementation of the ACA; this included all of the directors from the northeast region. While some directors reported having no clear role in the implementation of the ACA in their state, most were involved with strategic planning, advising, or consultation. Some directors also reported being involved in the development and implementation of behavioral health homes as part of the ACA.[6]

Directors reported that the Affordable Care Act has created opportunities, such as the inclusion of mental health services within the essential health benefit and parity between physical health and behavioral health services. Another opportunity that directors perceived related to ACA is for greater integration of behavioral health with primary health care. Directors expressed that integration has the potential to increase access to mental health services for children and their families, including early identification of needs and better coordination of care.

Another opportunity associated with the ACA identified by directors was a shift from a singular focus on treatment to primary prevention of behavioral health disorders. Responses suggested a growing recognition in states regarding the benefits of prevention and early intervention, especially in the context of concerns over rising healthcare costs and the additional costs that parity between behavioral and physical healthcare will bring. Directors expressed optimism that the current sociopolitical climate makes this an ideal time to push for more prevention and mental health promotion initiatives, which have the potential to impact long-term costs of care. This optimism, however, was tempered by directors' acknowledgement of the potential difficulties associated with finding the resources to support prevention and early intervention efforts. Despite these challenges, findings from this study highlight the continued call to embrace a public health approach to children's mental health, much like the one described in *Unclaimed Children* and *Unclaimed Children Revisited*.[16, 18] Failure to fund prevention and early intervention services for children

could ultimately cost states more money through the use of emergency medical services and the need for intervention by other public systems such as juvenile justice, education, and child welfare.[28] Additionally, as children with untreated mental health needs become adults who may require more intensive interventions than if their problems had been addressed earlier, unequal funding between child and adult services is perpetuated.

Along with the opportunities for children's mental health, directors also identified some challenges inherent in the implementation of the ACA. For example, some directors expressed concerns that children will be forgotten amidst all the activity associated with implementation of the ACA. This concern was expressed in light of directors' experiences with children's mental health frequently lacking priority in state planning and funding, which was reported to be predominantly adult focused. As identified by Knitzer and Olson and Cooper et al., children's behavioral health issues cross several state agencies and service sectors, including education, child welfare, and juvenile justice.[16, 18] Directors expressed concerns that treating the children's mental health system as parallel to or as a subset of the adult mental health system fails to recognize the cross-agency, cross-sector coordination needed to adequately address the behavioral health needs of children and their families. Additional research examining how issues facing children's services differ from those facing adult services would be useful to provide a context for understanding these differences.

*Expansion of systems of care* Related to directors' identification of differences in the nature of child and adult services, in response to open-ended survey questions, directors highlighted the expansion of SOC as an opportunity for children's mental health. Findings suggest that state child mental health directors have embraced or are moving toward the SOC approach in the planning and delivery of children's mental health services. Directors expressed a need to emphasize an expanded array of services in homes, schools, and communities. Furthermore, directors identified the importance of collaborative relationships across child-serving agencies to integrate systems and coordinate care for families. Such collaborative systems delivery is one of the key characteristics of SOC. However, because the current study did not directly address SOC, additional research is needed to more fully examine such collaborative endeavors across state children's mental health agencies and other child-serving systems.

These results suggest that the SOC approach to service planning, integration, and delivery is an important approach used by children's mental health directors to shape and organize behavioral health and related services from other state agencies and sectors. However, while directors saw SOC as a driving ideology, less than half reported having local entities with authority in their states. Because a key characteristic of SOC is its community-based, family driven nature, this lack of local entities creates a particular challenge to implementing local systems of care.

## Implications for Behavioral Health

It is evident that much has changed in the children's mental health care system. Notably, much needed services have become increasingly accessible to the most economically disadvantaged segment of the population through the inclusion of an array of children's mental health services covered by Medicaid. Further expansion of service availability and accessibility is expected to come through the Patient Protection and Affordable Care Act. While there are many opportunities on the horizon, findings also highlight the fact that significant challenges still remain. A strong state structure to support child mental health with clear lines of authority and influence is of utmost importance. As time passes and transformations within the health system continue, it is important to track what occurs in state CMH offices as a result of health reform and how these changes impact children with mental health needs and their families.

## Compliance with Ethical Standards

*Conflict of Interest Statement* The authors of this study have no conflicts of interest to report.

## References


1. Merikangas KR, He JP, Burstein M, et al. Lifetime prevalence of mental disorders in US adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry.* 2010; 49(10): 980-989.
2. Kessler, RC, Berglund P, Demler O, et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry.* 2005; 62(6): 593-602.
3. Merikangas KR, He JP, Burstein M, et al. Service utilization for lifetime mental disorders in U.S. adolescents: Results of the national comorbidity survey-adolescent supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry.* 2011; 50(1): 32-45.
4. Merikangas KR, He JP, Brody D, et al. Prevalence and treatment of mental disorders among US children in the 2001-2004 NHANES. *Pediatrics.* 2010; 125(1): 75-81.
5. Patient Protection and Affordable Care Act (ACA), 42 U.S.C. § 18001 et seq. (2010).
6. Barry CL, Huskamp HA. Moving beyond parity – Mental health and addiction care under the ACA. *The New England Journal of Medicine.* 2011; 365: 973-975.
7. Beronio K, Glied S, Frank R. How the Affordable Care Act and Mental Health Parity and Addiction Equity Act greatly expand coverage of behavioral health care. *Journal of Behavioral Health Services and Research*. 2014; 41(4):410-428.
8. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, H.R. 1424-117 § 511 et seq. (2008).
9. McCabe MA. *Health Care Reform as a Vehicle for Promoting Children's Mental and Behavioral Health.* Washington, DC: Institute of Medicine, 2015.
10. Frank RG, Beronio K, Glied SA. Behavioral health parity and the Affordable Care Act. *Journal of Social Work in Disability and Rehabilitation.* 2014; 13(0): 31-43.
11. National Conference of State Legislatures. *Mental Health Benefits: State Laws Mandating or Regulating*. Available online at http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx. Accessed on May 3, 2016.
12. Kaiser Family Foundation. *Status of State Action on the Medicaid Expansion Decision, as of September 30, 2013*. Available online at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. Accessed on May 3, 2016.
13. Behrens D, Lear JG, Price OA. *Improving Access to Children's Mental Health Care: Lessons from a Study of Eleven States*. Washington, DC: Center for Health and Health Care in Schools, The George Washington University, 2013.
14. Koh HK, Sebelius KG. Promoting prevention through the Affordable Care Act. *The New England Journal of Medicine.* 2010; 363: 1296-1299.
15. Croft B, Parish SL. Care integration in the Patient Protection and Affordable Care Act. *Administration and Policy in Mental Health and Mental Health Services Research.* 2014; 40(4):258-263.
16. Knitzer J, Olson L. *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*. Washington, DC: Children's Defense Fund, 1982.
17. Bertram R, Blasé K, Shern D, et al. *Policy Brief: Implementation Opportunities and Challenges for Prevention and Promotion Initiatives.* Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), 2011.
18. Cooper JL, Aratani Y, Knitzer J, et al. *Unclaimed Children Revisited: The Status of Children's Mental Health Policy in the United States*. New York, NY: National Center for Children in Poverty, 2008.
19. Annie E. Casey Foundation. *Kids Count Data Center*. Available online at http://datacenter.kidscount.org/. Accessed April, 2014.
20. Bernard R. *Research Methods in Anthropology: Qualitative and Quantitative Approaches, third edition.* Walnut Creek, CA: AltaMira Press, 2002.
21. Substance Abuse and Mental Health Services Administration. *Substance Abuse and Mental Health Block Grants*. Available online at http://www.samhsa.gov/grants/block-grants. Accessed July, 2015.
22. Stroul BA, Friedman RM. *A System of Care for Children and Youth with Severe Emotional Disturbances* (Revised edition). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1986.
23. Substance Abuse and Mental Health Services Administration. *Cooperative Agreements for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances*. Available online at http://www.samhsa.gov/grants/grant-announcements/sm-15-009. Accessed July, 2015.
24. Ali MM, Mutter R, Teich JL. *The CBHSQ Report: State Participation in the Medicaid Expansion Provision of the Affordable Care Act: Implications for Uninsured Individuals with a Behavioral Health Condition*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2015.
25. Medicaid.gov. *Behavioral Health Services*. Available online at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html. Accessed October, 2015.
26. Friesen BJ, Koroloff NM, Walker JS, et al. Family and youth voice in systems of care: The evolution of influence. *Best Practices in Mental Health.* 2011; 7(1): 1-25.
27. Cooper JL, Aranti Y. Children's mental health policies in the United States: Perspectives from advocates and state leaders. *Health Expectations.* 2015; 18(6):2213-2222.
28. Miller J. *Too Significant to Fail: The Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illness, for their Families, and for their Communities*. Alexandria, VA: National Association of State Mental Health Program Directors, 2012.