

Cross-System Prevention and Early Intervention for Children's Mental Health



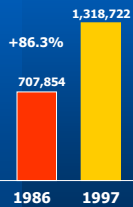
Larke Nahme Huang, Ph.D.
American Institutes for Research
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What's happening to our children?

A National Picture
Findings of President's New Freedom
Commission on Mental Health

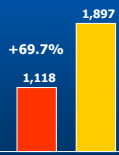
Children's Use of Mental Health Services

Number of Youth Admitted for Mental Health Service in the US.



1986 1997

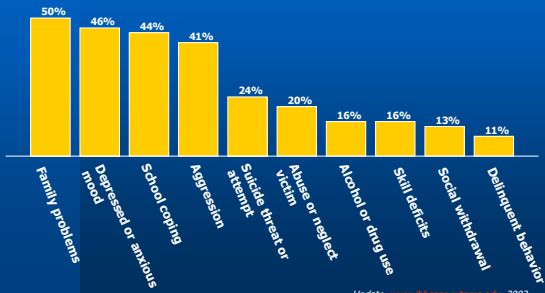
Cases of Mental Health Service Use per 100,000 US Youth Population



1986 1997

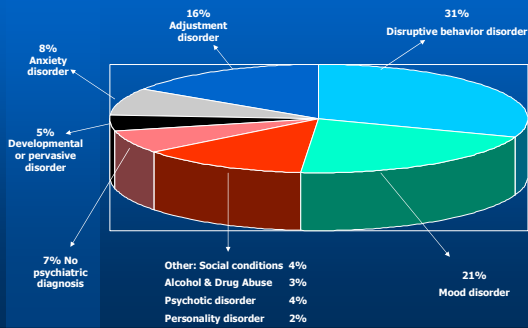
*Inpatient & Outpatient MH Clinic Services Only
Dept. HHS, Rutgers Univ., Annie Casey Foundation, 2002*

Presenting Problems of Youth Admitted to MH Services: 1997



Update: www.khccar.utdallas.edu, 2002

Prevalence of Psychiatric Diagnoses of Youth Admitted for MH Services: 1997



Selected Findings:

- 20% adults/children have a mental health problem
- 1/2 have a serious emotional disorder
- 13% of preschoolers have emotional/behavioral disorder
- 20 million suffer from serious disabling mental illness
- 2 million youth (SGR, 1999)
- Suicide: ~30,000 a year [80/day]
 - ~40% had contact with primary care provider within the last month
 - Adolescents 15-19y/o: 3rd leading cause of death; 17-19% think about killing themselves; 5-8% make attempt; only 1/3 get treatment
 - States spend over \$1 billion on medical costs associated with suicides and suicide attempts by youth under age 20 (NGA/CDC 2005)

YET,

- Less than half of individuals with serious mental illness get treatment, services or supports
- As currently structured, we cannot meet the needs of our children with mental health disorders.

More Children with MH Disorders in Non-Mental Health Systems

- Of children with serious emotional/behavioral disorders: ~50% drop-out of high school (compared to 30% of students with other disabilities)
- Youth entering Juvenile Justice: ~66-75% have serious emotional problems (*Coalition on Juvenile Justice; Teplin*)
- 1/3 children in mental health system have a co-occurring disorder (~age 11; ~age 17-18 SA)
- 12% of youth in pediatric settings have substantial psychosocial difficulties (*Kelleher, 2000*)

Children in Foster Care

- ~500,000 children in foster care: estimates up to 40-80% have emotional/behavioral and/or substance abuse problem;
 - 44% < 5 yrs old;
 - highest % of < 1yrs olds are Latino;
 - of Latino youth in foster care, 57% < 5yrs old(*The AFCARS Report: Preliminary FY 2001 Estimates as of March 2003; Washington, D.C., DHHS, 2003. Latest federal statistics on foster care supplied by the states for the Adoption and Foster Care Analysis and Reporting System: Zero to Three*)
- Ages 6-14 in foster care: have 4x behavioral/emotional problems as peers (*Vandivere, et al., 2003*)

Disparities for Children of Diverse Racial and Ethnic Groups

- Black and Latino kids identified/referred at same rates as general population, but less likely to receive specialty mental health or meds (*Kelleher, 2000*)
- African American and Latino children have highest rates of unmet need (*Sturm, 2000*)
- Asian American and Latino female teens have highest rates of depression (*Commonwealth Fund, 1997*)
- Among 14-18 year olds: 1 in 5 Latino girls attempts suicide (*CDC, 2005*).

Disparities for Children of Diverse Racial and Ethnic Groups

- Minority children tend to receive mental health services through juvenile justice and child welfare systems more often than through schools or mental health setting (*Alegria, 2000*)
- In child welfare, minority youth have poorer outcomes, fewer services, less likely to have plans for family contact and more likely to be in out-of-home placements (*Courtney et al, 1996*).

Rural Disparities

- Rates of mental disorders are similar between rural and urban youth, although limited sampling in rural America
- Exception: Rural adolescents have higher rate of suicide than urban counterparts
- Significantly higher rate among Native American youth
- Child poverty higher in rural areas: children of color at-risk with 46% African American, 43% Native American and 41% Hispanic rural children in poverty

Conclusion:

- **A Public Health Crisis in Children's Mental Health...**
 - Yet, a lack of responsiveness or outrage?
- **New Freedom Commission called for "Transformation"**

What does the system look like for children and families?

Who gets services?

- Most troubled youth do NOT get needed care.
- 75% are NOT being treated
- Ethnic/racial disparities: Persistent lack of access, poor quality care and poor outcomes - with Hispanic youth least likely of all to access specialty care

How much does it cost?

- Current estimated annual bill for caring for troubled youth is \$12 billion
- Adolescents: 60% of total costs, yet are only 35% of the population
- Children (ages 6-11) – 35% of cost, 35% of population
- Preschoolers (ages 1-5) account for 5% of costs, 30% of population

What type of care is provided?

- Outpatient treatment – most common
- Shift from inpatient to community services for children
- Outpatient care – nearly 60% of all mental health expenditures
- Only 5-7% of all youth are treated by mental health specialists each year.
- Most care is not provided in Mental Health System

Use of Psychotropic Medications

- > \$1 billion spent in 1998 on psychotropic medications, to treat on average, 4% of all youth (ages 6-17)
- Stimulants: most common in ages 1-11
- Antidepressants used nearly as often as stimulants for adolescents.

(RAND, 2001)

Who Pays?

- Privately insured youth account for nearly half of total mental health expenditures
- Medicaid recipients generate only about 1/4 of the costs (but use more services/recipient).
- Schools

Estimated Annual Expenditures for Mental Health Care (1998, in millions, RAND)

	All Youth ages 1-17	Preschoolers ages 1-5	Children ages 6-11	Adolescents ages 12-17
Outpatient	\$6,670	\$426	\$2,520	\$3,724
Inpatient	3,870	209	1,032	2,628
Medications	1,068	42	439	586
Other MH	74	20	22	32
Total	\$11,681	\$698	\$4,013	\$6,971

Dilemma:

spending \$12 billion on only 25% of youth who need care?

"Growing numbers of children are suffering needlessly because behavioral, emotional and developmental needs not being met by the institutions designed to address them."

(Surgeon General Satcher, 2001)

Prevention and Early Intervention: Part of the Solution

- Recognition of need for prevention, early identification and early intervention
- Requires “sea change” in attitude and commitment
- Recognition that prevention works
- Opportunity to engage underserved ethnic populations

New Freedom Commission: expanded beyond Executive Order to include prevention, early intervention

What do we need to do to move ahead with Prevention/EI?

New Freedom Commission on Mental Health

Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice

- Promote the mental health of young children.
- Improve and expand school mental health programs
- Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies
- Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Eyes on California

- Mental Health Services Act – “transformative?”
- “Little Hoover Commission”
- AB 34
- “Who’s Serving California....” – Workforce Development Strategy
- Multiple System of Care grants
- Prevention/EI Component of MHSA
- Competing tensions of evidence-based, family driven and culturally competent care

What do we know about screening, early identification?

- 36% of children at risk for suicide received treatment or counseling
- Yet a promising intervention of depression screening and intervention → lowered rates of suicide
- Early screening of high risk youth combined with psychosocial interventions, parental education can prevent negative consequences of conduct disorder (Feil et al., 1995).
- Use of brief screening for depression in pediatric settings increases the recognition of mental disorders. (AHRQ, 2002)
- Existing screening tools with good specificity and sensitivity for emotional/behavioral and substance use disorders

A Comprehensive Approach to Prevention and EI

- Combined top-down + bottom-up – community and family voice in prevention efforts
- Seamless, multidiscipline, multi-setting system of prevention/EI – targeting multiple risk factors; not a single risk factor strategy
- Coordinate funding, regulation, and oversight of prevention services across agencies and departments;
- Create MH indicators for each measurement of risk and protective factors;
- Remove barriers to coverage of prevention and screening
- Develop opportunities to screen children in multiple settings
- Build on expanding knowledge of “what works”

A Clearly Stated Rationale and Fiscal Strategy for Program of Prevention

Emerging Research:

- Research has identified numerous malleable influences on child's development, e.g. non-invasive imaging techniques can show impact of psychological trauma, maltreatment, sensory neglect, and the role of experience on developing brains of children.
- Logical to intervene before beyond becomes intractable.
- Many adult disorders have their origins childhood (Kessler)
- Children best served in their natural settings, e.g., home, school, health care clinics
- Increasing fiscal analyses showing return on prevention investment
- Prevention/EI programs – form of economic development; make the business case

6 Major Barriers to Promotion, Prevention/Early Intervention.

1. No clear infrastructure for delivering prevention and EI services
2. Few training opportunities re screen/identify early warning signs for families, teachers, health practitioners and MH clinicians to make facilitated referral
3. Lack strategies for delivering evidence-based prevention/EI services; gap between science and service
4. Resources for evidence-based Prep/EI are limited and low priority in overstretched systems.
5. Lack of public advocacy
6. Insulated within systems; lack cross-over or comprehensive, coordinated approach to prevention/EI; prevention dispersed across systems

What are we learning about investments in Prevention/EI within, beyond and relevant to the mental health care system?

Investment in Quality Pre-K and Child Care

- High/Scope Perry Preschool Program, Michigan –**
low-income families, primarily African American child age 3-4.; randomized study
- 20 Year Outcomes: reduction in crime, welfare, remedial education
 - Savings: \$7.16 for every \$1.00 invested.
 - Rate of Return: 16% over 20 years (Long-term return on U.S. stocks, 7%. Initial investment of \$1,000 – return over \$19,000.)

Investment in Quality Pre-K and Child Care

Chicago's Child-Parent Centers (low-income neighborhoods)

- Served over 100,000 4 year olds since 1967.
- Non-attendees: 70% more likely arrested for a violent crime by age 18.
- \$7 saved for every \$1 invested in this program

Investments in Schools

- Evidence-based school prevention/EI exists. Major barriers to implement/sustain
- De facto MH system: 70% of youth receiving mental health services receive them within school settings
- Prevention/EI must be linked with academic outcomes – otherwise ancillary and “additional burden”

Investment in After School Programs

Quantum Opportunity Program vs. CA's Three Strikes Law

- After School hours – prime time for juvenile crime
- QO: high school program
- 6 year follow-up: nonparticipants averaged 6x more criminal convictions
- QO benefits: \$3 per \$1 spent
- RAND study: per dollar spent, QO prevented more than 5 times as many serious crimes as Three Strikes Law

Investment in Primary Care

- Primary Care: natural setting, first point of contact
- Where children come regularly, non-stigmatizing
- Readily accessed by underserved ethnic, racial populations who tend not to use mental health services
- Acknowledge importance of socio-emotional health, critical component of overall health and well-being
- Normalize, as with vision, hearing exams
- Potential for stigma reduction (parents want pediatricians to address mental health issues)
- Engage primary caregivers in support of social, emotional health
- Provide anticipatory guidance, support, skill-building with child and caregivers

Investment in Primary Care

- AHRQ (2002) Brief screening for depression in pediatric settings increases recognition and leads to appropriate referrals
- Majority of children screened for behavioral health concerns do not require child-specific treatments – but calling attention to concerns provides support for preventive interventions (parent education, parent support, social skills practice, etc.) (Knitzer, 2002)
- “Bridge” programs that integrate “community counselor” in ethnic-specific community health clinics (Chung; Soohoo, 2000)

Investment in Violence Prevention

Effective prevention focuses on:

- (1) helping children use problem-solving skills
- (2) aiding families in parenting skills

- Metro Area Child Study Prevention Program (Tolan): reduced aggression and fighting by 1/3; 15% drop in arrests in 8th grade; improved academic performance
- Washington State Public Policy Institute: returns of up to \$31 for each prevention dollar.
- Prevention /EI: good empirically supported policy to lessen violence among youth
- Needs bottom-up/top-down advocacy

Investment: Interface of Child Welfare & EI

- Part C of IDEA: young children victims of maltreatment are eligible for EI services; must receive evaluation of EI needs within 45 days of referral to Part C.
- 16.4% of every 1,000 children ages 0-3 have substantiated case of maltreatment.
- More eligible for EI services due to maltreatment than to Mental retardation, CP, hearing, vision impairments
- Result: new population for EI system
- EI & CPS: both serve at-risk children; operate separately
- EX: analysis of children 0-3 in Colorado CPS: over 60% eligible for EI based on clinical/developmental needs; < 5% served in Part C (EI) systems (Robinson, et al., 2003)

Investment in Family-Centered Model

- Impact of Parental Mental Illness/SA on children-major risk factor for children
- For Example: Maternal depression: known risk factor for
 - Lower language productivity in young children
 - Disruptive behavior; involvement in violence
 - Poorer academic performance
 - Childhood depression
 - Poor health and safety practices
- Two-generational intervention/prevention strategies with family - not individual – as unit of focus.
- Expand beyond services restricted only to the individual

Investment in Children & Families: Substance Use

- Identified stable developmental trajectories associated with SU
- Childhood antisocial, conduct disorders, anger, anxiety – predictive of SU in adolescents
- Early childhood aggression – major focus, developmental marker
- Children of Alcoholic/Drug Abusing Parents – highest risk group
- Trend to: community partnership, mobilization, family strengthening; school-based skills training
- Gender differences in prevention approaches

Attention to Culture/Ethnicity

- Insufficient research/evaluation
- Responses may differ as function of ethnicity and culture
- Ethnic representation in prevention research – variable
- Emerging studies

YET:

Prevention may be more accessible, acceptable for diverse, un/underserved ethnic populations; carries less stigma

Changing the Access and Quality Paradigm for Diverse Ethnic Groups

An Example: Tuberculosis Prevention/Interventions in Refugee Communities:

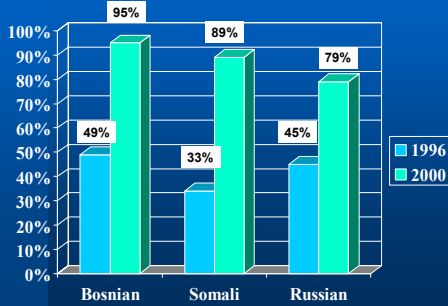
Cultural Case Manager Model
(Chaulk, et al., 2004)

Community-based Cultural Case Manager Model

- Builds on the “local knowledge” of the target neighborhood. (System navigator)
- Cultural competence as not just skin color or language fluency
- Relies on “Neighborhood Health Messengers”—trusted, credible people from the community—who can translate information into and out of the neighborhood (“two-way flow of information”) and help bridge the worlds of vulnerable families and public systems
- Incorporates team orientation with communities and community residents—not just doctors, nurses and professionals seen as experts.

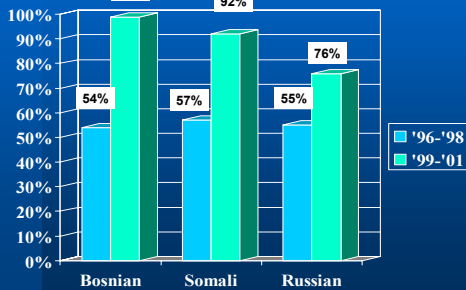
Therapy Completion Rates ('96-'98 vs. '99-'01)

N = 319



Therapy Acceptance Rates ('96-'98 vs. '99-'01)

N = 389



Ongoing Challenges...

- Continuous Evaluation of Prevention/EI
- Applicability to diverse ethnic/racial communities
- Getting information about effective P/EI to practitioners and communities
- Build Prevention/EI approaches into system of care framework (beyond deep-end, treatment focus)
- For any given system: identification of evidence-based Prevention/EI to target specific community risk factors
- Developing coordinated strategic financing plan (in context of economic development)
- Developing professional/paraprofessional training and development
- Engaging Political and Public Will

Vision for Prevention

- How fit within system of care approach/community services and supports?
- Build on community risk and protective factors, engage diverse communities
- Insert community-driven prevention into system of care infrastructure?
- Expand mental health - not just associated with deep-end children
- Coordinated, comprehensive prevention effort?
- Pooling different funding streams – block grants (Child Care, etc.), MHSA, IDEA, SCHIP, EPSDT, ESEA)
- Need for cross-disciplinary, cross-system thinking

Components of Transformation

Former Surgeon General, Dr. Julius Richmond



Thank You.

Larke Nahme Huang, Ph.D.
LHuang@air.org
202-403-5180
