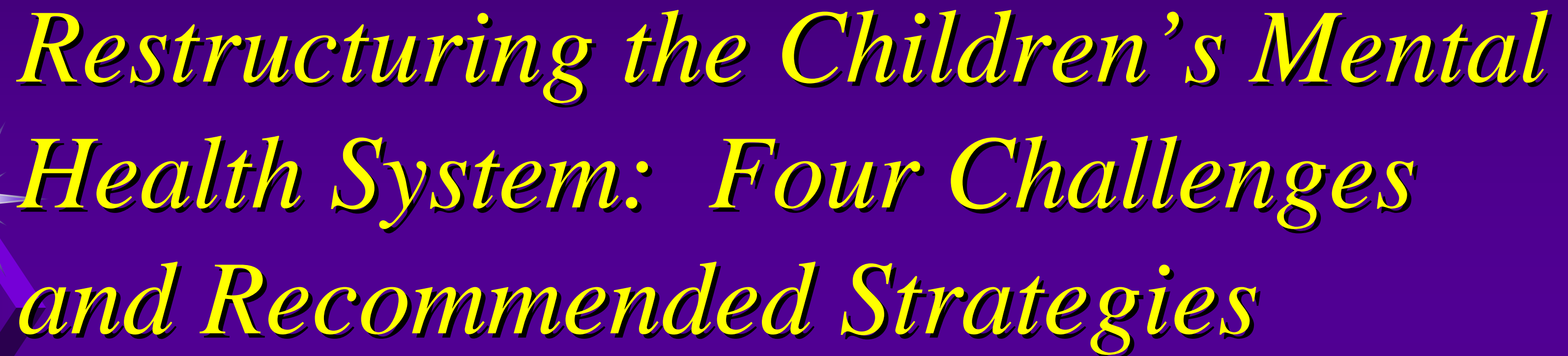

Restructuring the Children's Mental Health System: Four Challenges and Recommended Strategies

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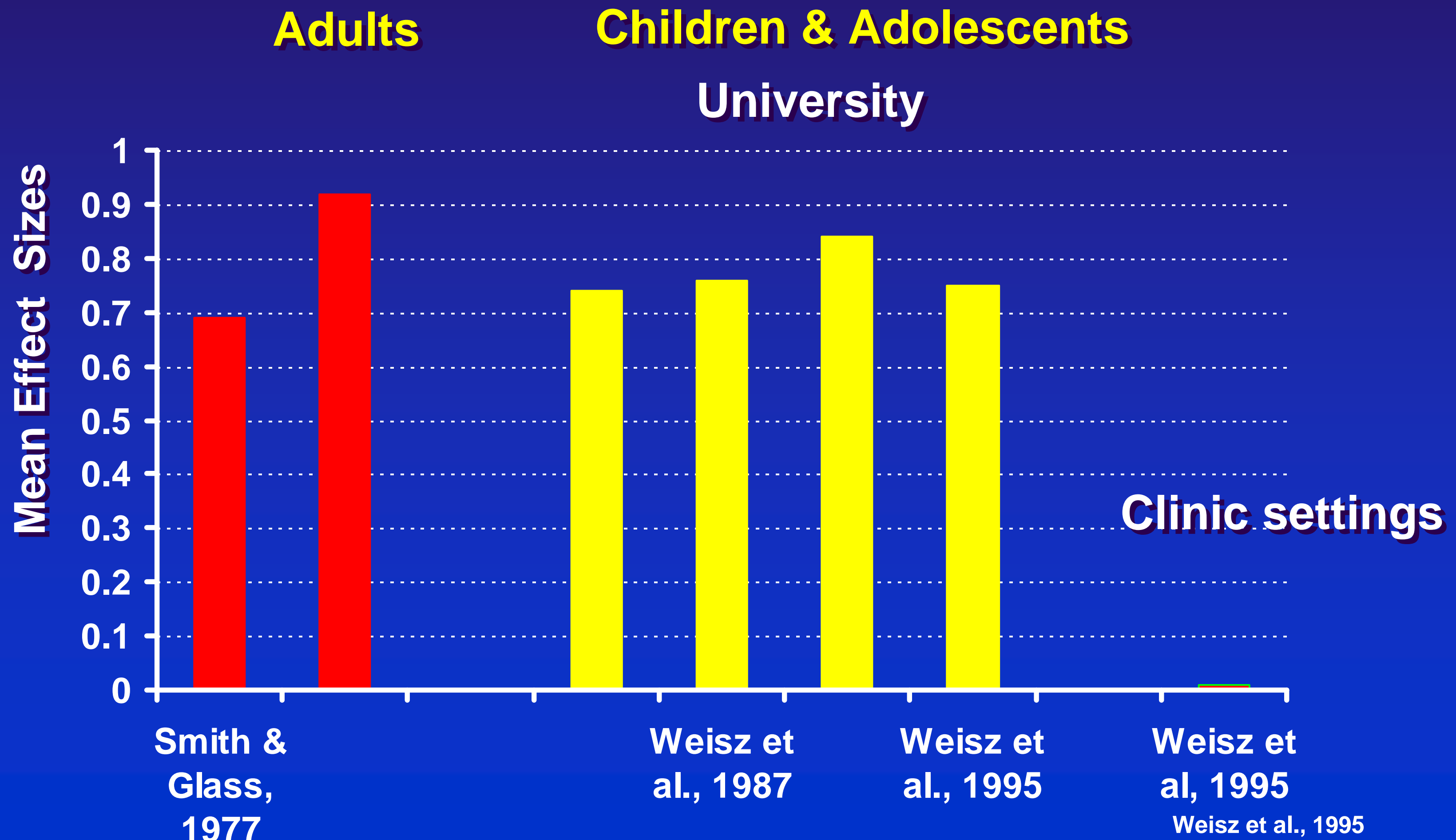
Challenge #1: Content of usual care is generally ineffective. Yet effective interventions are known.

- Poor quality for most children and families (USPHS, 2002; Bickman, 1996; Weisz et al., 1995; 2005; Landsverk et al., 2006)
- Yet effective interventions exist for most of the common child and adolescent problems.

Psychotherapies provided in routine clinical care have little to no effect (Weisz et al., 1995)



18 Major Reviews of Evidence-based Interventions for Children (1998-2007)

- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. Journal of Consulting & Clinical Psychology, 66(1), 7-18.
- Brestan & Eyberg (1998). Journal of Clinical Child Psychology, 27:180-189.
- U.S. Public Health Service. (1999). Mental Health: A report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health
- Weisz, J. R., & Jensen, P. S. (1999). Efficacy and effectiveness of child and adolescent psychotherapy and pharmacotherapy. Mental Health Services Research, 1(3), 125-57.
- Kaplan, S. J., Pelcovitz, D., & Labruna, V. (1999). Child and adolescent abuse and neglect research: a review of the past 10 years. Part I: Physical and emotional abuse and neglect. Journal of the American Academy of Child & Adolescent Psychiatry, 38(10), 1214-22.
- Olds, D., Robinson, J., Song, N., Little, C., & Hill, P. (1999). Reducing risks for mental disorders during the first five years of life: A review of preventive interventions. Rockville, MD: Center for Mental Health Statistics.
- Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. Clinical Child & Family Psychology Review, 2(4), 199-254.
- Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. Clinical Child and Family Psychology Review, 3(4), 223-241.
- Webster-Stratton, C., & Taylor, T. (2001). Preventing violence in adolescence with interventions for young children. Prevention Science, 2(3), 165-192.

18 Reviews of EBPs

- Greenberg, M. T., Domitrovich, C., & Bumbarger, B. (2001). The prevention of mental disorders in school-aged children: Current state of the field. Prevention & Treatment, 4(1).
- U.S. Public Health Service. (2001). Youth Violence: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health
- OJJDP Model Programs Guide (www.dsgonline.com/mpg2.5/mpg_index.htm
- Burns, B.J, & Hoagwood, K. (Eds.). (2002). Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders. New York: Oxford University Press.
- Kazdin, A. E., & Weisz, J. R. (2003). Evidence-based psychotherapies for children and adolescents. New York, NY: Guilford Press.
- Weisz, J. R. (2004). Psychotherapy for children and adolescents: Evidence-based treatments and case examples. New York, NY: Cambridge University Press.
- Burns, B. J., & Hoagwood, K. (2004). Evidence-based practice, Part I: Research update. Child and Adolescent Psychiatric Clinics of North America, 13, xi– xiii.
- Burns, B. J. & Hoagwood, K. (2005). Evidence-based practice, Part II: Effecting change. Child and Adolescent Psychiatric Clinics of North America, 14, xv– xvii.
- Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Rolls Reutz, J. A. (2006). Mental health care for children and adolescents in foster care: Review of research literature. Seattle, WA: Casey Family Programs.

Definition of empirically-supported or evidence-based interventions

- Psychosocial, medication, preventive or service interventions tested through controlled group design studies or multiple single-case design studies (Lonigan, Elbert, & Johnson, 1998; Chambless & Hollon, 1998).
  - That use standardized outcome assessments post-intervention
  - That demonstrate consistent positive effects in favor of the experimental intervention; and
  - That include a manual or standardized training materials for replicability.
- However, how well an intervention works, and how well it is implemented, are two different things (Schoenwald, 2006)

Strength of the evidence

- **More than 1500 published clinical trials on outcomes of psychotherapies for youth**
- **Effect sizes for psychosocial treatments for children range from .5 to .8 (Weisz et al., 2005). These effects are as robust as those for adults reported through meta-analyses (Kazdin &Weisz, 1998; Weisz et al 1987; 1992; 1995; 1998; 2004)**
- **More than 300 published clinical trials on safety/efficacy of psychotropic medications and growing**
- **Approx 50 field trials of community-based services**
- **34 effective preventive interventions cited by Greenberg et al, 2001**
- **47 effective school-based interventions cited by Rones & Hoagwood (2000)**
- **24 effective school based interventions targeting both academic and mh outcomes (Hoagwood et al., 2007)**
- **7 effective trauma-related interventions for youth (Landsverk et al., 2006)**
- **19 effective programs for disruptive behavior disorders (Burns et al., 2007)**

Challenge #2: Workforce poorly prepared to deliver effective interventions

- Re-tooling of the workforce is occurring in at least a dozen states: (NY, CT, MA, MD, NH, MI, OH, OR, CA, WA, OK, CO) (Bruns & Hoagwood, in press)
  - Multi-systemic therapies (MST)
  - Functional family therapy (FFT)
  - Treatment foster care (TFC)
  - CBT for trauma
  - CBT for depression
  - Range of behavior management programs for parents of children with disruptive problems
- New York: 400 clinicians per year receiving training and year long intensive consultation on specific EBPs for children
- Yet the structures for sustaining this do not exist
- Inefficient substitute for what graduate programs should be offering
- Training/consultation for supervisors and parent advisors are often ignored

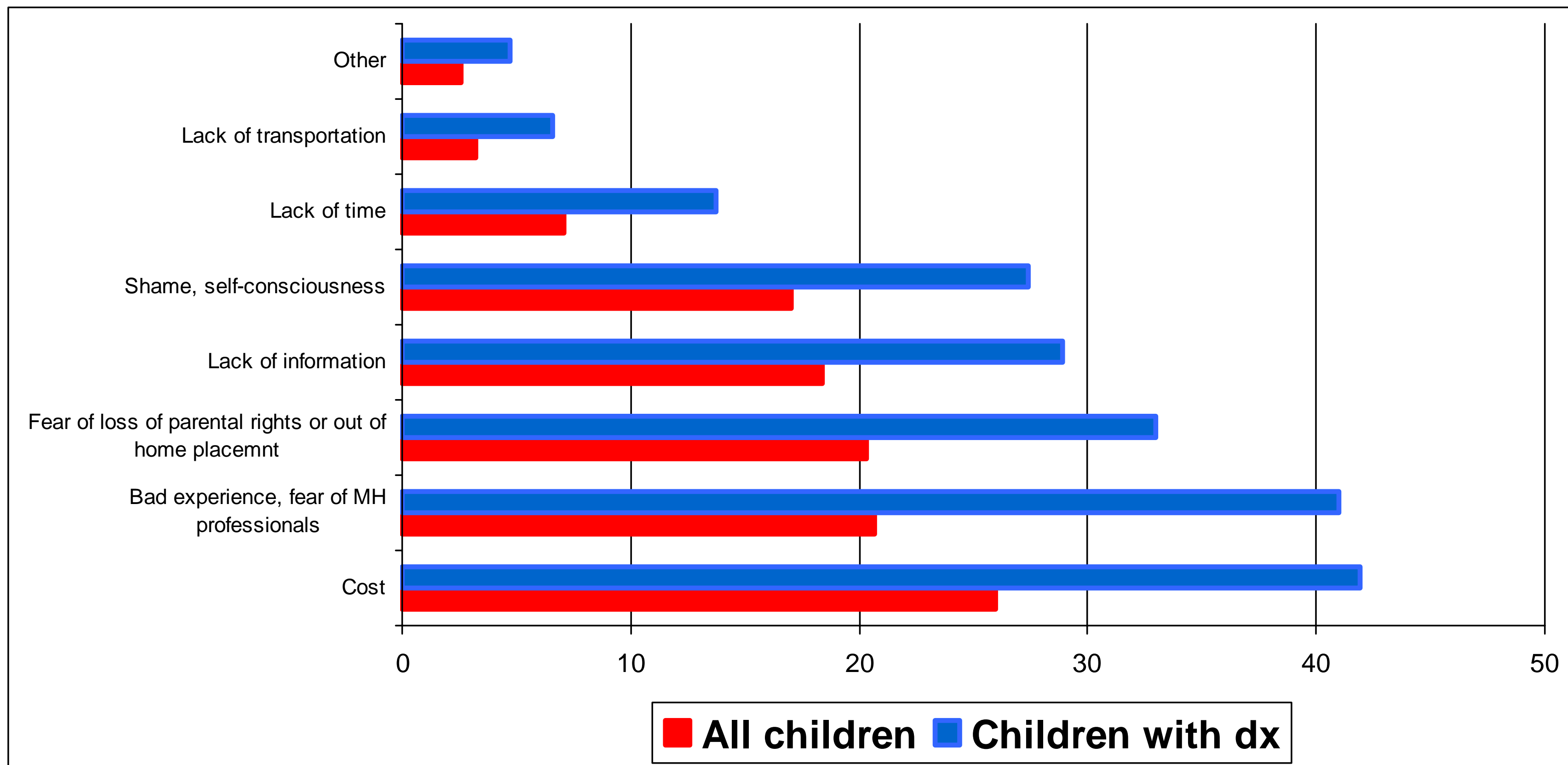
Challenge #3: Shame and strain on youth and families

- The shame factor: Youth and families experience blame; have widespread distrust of professionals; have concerns about losing custody; are often unable to pay for care
- The strain factor: Youth and families have to glue services together
  - Extreme system segregation and fragmentation
  - Up to 92% of adolescents with serious mental disorders receive mental health services from two or more systems and 19% from four or more (Hoven et al., 1998)

Need and use of services among youth in non-specialty sectors

- Schools: 70-80% of youth reporting use of MH services say they receive them in schools (Burns et al., 1995)
- Primary care
  - Significant under identification (Costello, 1986, 1988; Dulcan et al., 1990; Horwitz, et al., 1998; Kelleher et al., 1997; 2000); unmet need among identified patients is 60% (Gardner, Kelleher et al., 2000)
- Juvenile Justice: 60-70% detained youth have psychiatric dx (Teplin et al., 2002)
  - Use: 15% (Teplin et al., 2005)
- Child Welfare
  - 52%-72% of youth have clinically significant MH needs (Glisson et al., 1994;1996; Horwitz, et al., 1994; Trupin et al., 1993; Garland et al., 1996; Landsverk et al., 1996; McMillan et al., 2004)
  - Use: 19-94% (Burns et al., 2004)
- Substance Abuse
- Informal services (homeless shelters, neighborhood centers, after school programs)

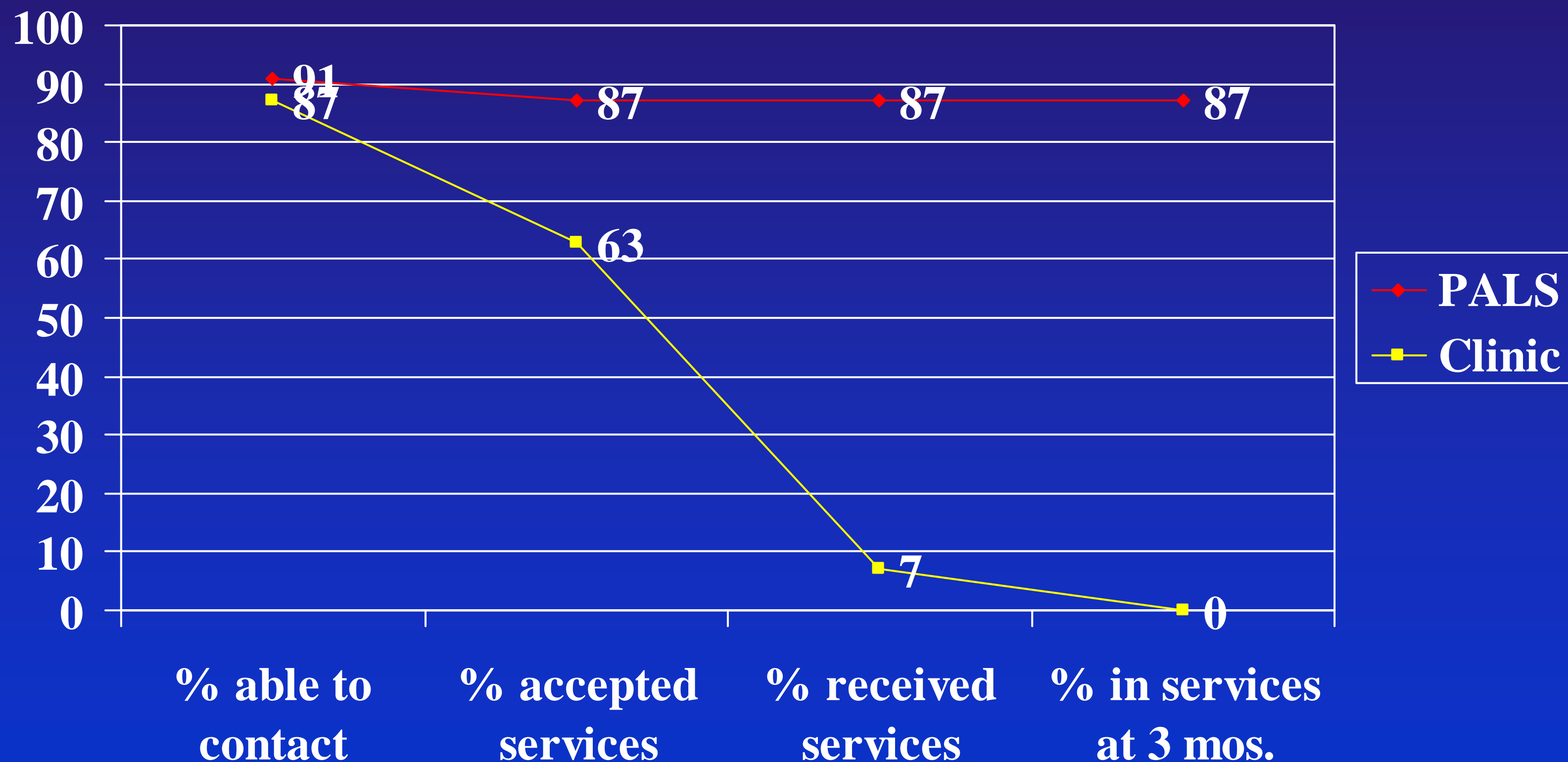
Barriers to seeking care for mental health problems: Percent citing reason for not seeking needed care (parent and-or child report, age 9-16). From The Great Smoky Mt Study, Costello et al., 2002



Evidence-based engagement interventions exist

- Reminders reduced missed appointments by as much as 32% (Kourany et al., 1990; McLean et al., 1989; Shivack et al., 1989; & Sullivan)
- Intensive family-focused telephone engagement intervention associated with 50% decrease in initial show rates and a 24% decrease in premature terminations (Szapocznik, 1988; 1997)
- Combined telephone and first interview engagement interventions associated with attendance rates of 74%, representing a 16 to 25% increase above the clinic comparison families (McKay et al., 1998).

Family service involvement: PALS engagement strategies vs. usual clinic (McKay et al., 2003)



Challenge #4: You can't manage what you don't measure

- Lack of systematic and ongoing measurement of outcomes in usual care
  - Yet validated outcome monitoring systems are available
    - http://peabody.vanderbilt.edu/x7278.xml
  - Outcome technologies for continuous decision-making and feedback also exist (Chorpita & Dalaiden, 2002; Bickman, 2006; Hodges, Wotring et al., 2005)
- Evidence-based organizational change interventions can improve climate and reduce staff turnover (Glisson, et al., 2006)

Recommended Strategies

- Give the tools of psychology away
  - Screening, assessments, guidelines, protocols, and other tools ready to go
- Democratize access to quality care
  - Training and workforce development needed, especially in non-specialty care
  - Train workforces across sectors (teachers, foster care workers, care managers, family life specialists, probation officers, clinicians)
- Workforce programs should include parent advisors, supervisors, and management teams, in addition to front-line staff
- Need full revamping of social work training to focus on EBP and core competencies
- Promote youth and family self advocacy, engagement and empowerment strategies
  - Support expanded roles for youth and family members within the profession; create new professional opportunities including certification and licensing for youth leaders and family members

Recommended Strategies

- Encourage adoption of standardized clinical decision-making outcome and feedback monitoring
- Expand research support on implementation and dissemination of EBPs writ large—including assessments, engagement, empowerment, organizational supports, monitoring systems
- Create regional mental healthcare collaboratives modeled on pediatric health centers to incentivize coordinated group mental health practices. These should include prevention, early intervention as well as targeted services for youth with severe disabilities within defined geographic areas.

Closing Thought

- Two decades of research in mental health services have yielded many significant findings.
  - How to screen and assess
  - How to identify risk and protective factors
  - What are effective intervention modalities
  - How to measure outcomes
  - How to engage and empower families
- We have instruments, guidelines, protocols, and other tools ready to go
- What is missing: A delivery system to get this knowledge to youth and families on their own turf and in ways that are useful to them.