**A PROPOSAL FOR A BROADER
SYSTEM OF CARE
TO ADDRESS MENTAL HEALTH NEEDS
OF CHILDREN
A PUBLIC HEALTH VIEW**

**EMPHASIS ON SEVERE MENTAL HEALTH NEEDS OF
CHILDREN WITH SPECIAL
HEALTH CARE NEEDS**
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National and State Call to Action on Mental Health

Time has arrived for all children's mental health care needs to be integrated and coordinated within neighborhood community and systems of care, bringing together services to promote children's healthy development and to foster resiliency. Building an early response capacity with child find, screening, surveillance will offer early intervention before serious disorders develop.

The need for a proactive universally-provided system to address mental health issues of children by pediatricians/family physicians, schools and other community providers, along with traditional mental health providers has been documented prior to the current recession. This proposal is not just a response to the shrinking dollars or shrinking of traditional services while needs are becoming greater in a stressed community. Rather, this document is to stress the need for a master plan and to provide suggestions to promote a dialogue for more integrated population-based, tiered, selected and targeted interventions.

The call to prioritize mental health in children was sounded at the national level by President Bush in his President's New Freedom Commission. Under President Bush, the Surgeon General's Public Health Service Report on Mental Health (1999) was published, documenting mounting mental health needs in children and families and calling for community-based, family, school and primary care collaboration. (www.surgeongeneral.gov/library/mentalhealth/home.html). In 2003, goals and recommendations were reformulated; delineating a significant role for public health professionals in helping transform the way the nation perceives and addresses mental health. Of the six goals, goals 1, 3, 4, and 6 emphasize the efforts where major involvement of the public health system is a necessity.
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The Healthy People 2010 Objectives for school-aged children's physical health provisions were expanded to include psychosocial emotional health (www.healthypeople2010). Although the relationship between health and mental health is well established and the call to action has been made at the national and state levels to reflect the 21st perspective, a master plan for Utah is not yet viable. We know work is in process with school and mental health steering committees, but an overall plan needs to be in place.

Introduction Purpose

The purpose of this paper is to briefly review the need for a broader community-based, integrated system with the public health perspective encompassing mental health. A newly conceptualized, coordinated system of care is proposed to promote healthy development and prevention with systems of early intervention and systems of care with a population-based focus.

Definition of Positive Mental Health:
We are providing a definition of positive mental health, as it is the basis of the model presented. Mental health encompasses how the child or adult thinks, feels, and acts when facing life situations. And, positive mental health exhibited when child or adult, in coping with every day stresses, deals with decision-making and his or her relationships in learning and loving with positive expectation.   Positive mental health is a critical component of children's learning and general health and is a national priority. Fostering social and emotional health in children supports their healthy development.

Documentation of the Need

In the document, Mental Health of Children and Youth and the Role of Public Health Professional produced by UCLA Center for Mental Health in the Schools: Program and Policy Analysis, a call is made for medical and mental health with public health to collaborate to make even greater improvements in care. Emphasis is place on: Understanding how social and other environmental context influences the etiology and prevention of mental illness by examining risk and protective processes and developing conceptual models of new strategies. In 2003 UCLA Center for Mental Health and Schools reported 12% to 22% of children sampled are in need of mental, emotional, and behavioral services. Yet, most children and adolescents diagnosed with mental disorders or at least mental impairment do not receive treatment. Also, 60-70% of the entire child adolescent sample received some mental health services in the health sector. The larger provider of mental health services to the population is the school system.

Christopher and Furukawa in their seminal study at a developmental assessment center (1990) found young children with developmental disabilities have significantly higher rates of serious mental health needs. The more the cognitive delay, the more severe the later psychiatric conditions. Mental health referral was made on 70% of the children at the developmental assessment center.

In a Children's with Special Health Care Needs (CSHCN) national survey (2005/06), children with special health care needs comprised 13.9% (other sources state 17%) of all the children in the U.S. In this survey, parents reported that mental health issues were second only to asthma as the major health problem and are fast becoming the number one priority. Although 38% of CSHCN children had mental health problems, only one-quarter of the caretakers recognized the need for the mental health services. Mental health needs of special health care patients were underestimated in younger children and slightly overestimated in adolescents. Low income and minority children with special needs have higher rates of mental health problems and are less likely than their counterparts to receive traditional mental health services. In addition, members of their families have unmet needs for mental health services. Children who are poor, uninsured, and without usual sources of care were statistically more likely to report mental health care needs unmet. The data suggested that broader policies to identify and connect families with

the needed services with child and family centered approaches alone will not meet the needs. More interventions for poverty stricken families and insurance expansion efforts were stressed.

In a longitudinal EPI Cure study Johnson, Hollois, Kochhar, Hennessy, Walke and Marlow (2010) found extremely preterm children were more than three times more likely to have a psychiatric disorder than classmates when evaluated at age eleven.

Primary Health Care Providers

In a 1999 study in the Boston area of primary care physicians caring for CSHCN children, only 18% of the physicians reported satisfaction with their ability to access outpatient mental health services for their patients, and only 12% were satisfied with their ability to access outpatient mental health services for their patients and families. In addition, only about 30% reported being satisfied with their ability to address their patients' psychological and emotional needs, and 77% reported that they needed more access to psychological consultation.

In the Utah Primary Care Provider Needs Assessment Survey of 2009, over half of the responding pediatricians reported a need for support in treating children with social-emotional issues and suggested that pediatricians would support further training meet the needs of the mental health issues in their patients.

The ABLE Program in Salt Lake City, Utah was a clinically-based program, serving school-aged children with special health care needs. In the last twenty years of the ABLE Program, the *Youth Outcome Questionnaire (YOQ)* was completed by the parents or guardians in each visit to assess the child's functional problems of daily living. The *YOQ* is a brief parent-report standardized measure of progress of children and adolescents and is meant to track actual change in daily functioning in the home rather than clusters of behaviors to support a diagnosis. (The *YOQ* was designed for use in mental health treatment centers and is also used in juvenile court settings). Our clinical experience supported the early findings on the YOQ of significant impairment in daily functioning and behavioral regulation, yet most parents faced barriers to needed traditional mental health intervention and did not seek treatment services. (ABLE Program data are not yet compiled). Michael Lambert, PhD., and other *Youth Outcome Questionnaire* researchers propose the use of *YOQ* with an additional new mental health outcome-tracking and intervention tool, which may be adapted to primary care physicians.

Barriers to mental health care:
Barriers for Families:
- Cultural and language/linguistic differences
- Racial and ethnicity issues
- Financial barriers
- Stigma of receiving mental health in the mental health setting
- Silo services—no fluidity across agencies
- Top-down treatment programs and rigid strategies
- Gate keeper system of insurance companies

Barriers for Professionals:
- Silo services--no fluidity across agencies
- Need for training in mental health issues and consultation support
- Time constraints
- Financial support and third party reimbursement

- Reluctance of professionals to support a comprehensive approach and ask the mental health questions
- Limited access to mental health consultation and referral resources, which are constantly changing
- Lack of mental health source for reference
- Difficulties entering into consultation and collaboration process.
- Few child psychiatrist
- Reduction in health system: single problem visits
- Gate keeper system of insurance companies

Some ideas of what we can do come from a newly proposed conceptual model:

Conceptual Model (discussion below is relevant to the triangle diagram in Appendix A: **A Broader Scope of Care: Promoting Positive Mental Health**).

This model presented here is a systems model and represents a shift in focus from the child to the many children in the broader environment especially in the local neighborhood setting: a shift to the systems-ecology of **population-based positive mental health**.

Population-based social-emotional and behavioral health, the large purple circle, is the broad system, the foundation for positive well-being and successful functioning in a child. The natural environments in which the child resides and functions day-to-day (daily moments, routine, transitions, activities, optimal experiences) are the arenas in which the foundation for positive mental health grows. It is this **population-based mental health**, which can be broadened, promoted and strengthened for risk-prevention, redirection and intervention before serious mental health disorder result. These sentinel resources (family, school and health care practitioner) within the community-based systems of care can be very present and providing in varying ways and generally assumed to largely care for children and families in the community. In addition, these population-based interventions (Tier I) contain resiliency promotion, early prevention, screening, and outcome measures, in the broader community as well as varying treatment potentials.

The diagram **A Broader Scope of Care: Promoting Positive Mental and behavioral Health** (Appendix A) is an attempt to describe the concept we are trying to convey. In the diagram the purple circle represents the broad universe of mental health. We are looking specifically at those aspects of the environment, which are healthy, and positive, not societal ills, which contribute to poor mental health, lowering resiliency and poor health. The inner portion of the triangle represents the varying levels of intervention. The **family**, **school** and **primary care providers/health care providers** are the people grounded in this broad universe of emotional and social health. Mental health becomes more individualized as it is anchored in the **family**, the **school** and **primary care providers**.

Programs are embedded in the community and affirm and strengthen families' cultural, racial, and linguistic identities and enhance their ability to function in a multicultural society. Programs are flexible and continually responsive to the emerging family and the constantly changing community.

The **family** (the primary attachment) provides the natural resources needed for daily survival/growth in all developmental domains. Family culture, extended family, social support, faith-based connections and neighborhood are covered under **family,** as well as **family advocacy. Families** are resources to their own members, to other families, to programs, and to communities. And those working with families are mindful of family preferences, goals, knowledge, strengths, and resources   Some **Families** turn to

f**amily advocacy** groups, such as the Utah Parent Center, National Alliance on Mental Illness, Allies for Children's Mental Health, Family Voices and Links for self-help and a political voice.

The School is the structured academic and social learning center, which provides a protected environment for positive mental growth. Many **Utah schools** began a school-based mental health promotion and protection intervention through the Utah Positive Behavior Initiative. As interventions for a specific child are needed, the intervention takes an individualized focus while emphasizing the contextual factors, as in Response to Intervention (RTI). The emphasis in RTI is on the function of the child while adapting the environment to better meet the needs of the child before moving toward the traditional medical model of analysis of the child's problems. The next level of intervention is the systematic selected population in Tier III for some systems in which the Educational Classification of the child is typically made

Primary care providers assess and track the child's developmental course and chronic medical condition. They support parents through education about development and provide positive protective resources. With parity and health care reform laws that recently passed, there is a renewed interest by primary care providers to be more active in addressing the mental health of their patients. **Primary care providers** are asking for knowledge, complimentary skills, collaboration and effective insurance billing/coding information to enhance mental health services in their practices. The Academy of Pediatrics, the largest professional organization representing care to children has recently set new standards for individual members to assume new knowledge and skills and attitudes with changing practices so by 2020, 60% of pediatric clinicians role will be represented with 20 to 30% MH content in their daily practice.

Some thing's we have done and what can we do?

Ideas for population-based interventions:
- Technological opportunities for interventions, which can reach a broader population
    - Wide scope, population-based coverage through television media campaign For positive mental health promotion.

    - Invite a dialogue with city planners/mayors to view community activities and spaces as mental health/wellness promotion.

    - Survey professionals and parents about best and most helpful websites for online use.

    - Form a coalition to assess the current resources and directories.—wide range of resources from community resources (after-school programs, Parks and Recreation, Big Brother/Big Sister, Community Gardens, Youth Programs, mentoring programs, etc, to specialized programs in private and public agencies (schools/school districts, Mental Health, Division of Family and Child Services, medical services, private providers and hospitals).

    - Continued assessment of schools and doctors about services provided. What can we count on being done by schools and by doctors?

    - Online specialized mental health community education with computer generated audio, visual, graphic and text support (visual audio pods)

Some Health Department and University population use prototypes
include:

Able-differently Website, www.able-differently.org , alias Able,
an awarded website for Excellence by the Governor
(2008), provides ways to construct management tools
for family health care workers and teachers. Content in
part includes ways to build teams and collaborate,
assessment instruments including free public domain
rating scales for screening and surveillance, using arts and
activity development toward building resiliency. (non profit plans to
continue website by Able-Differently program)

Medical Home portal website, www.medicalhomeportal.org.
a health care and family supported resource, continually managed for
medical, physical, educational content materials.   Mental health and other
psycho-social content is needed.
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o Electronic and teleconferencing using telehealth, go to meeting, and
other online computer based room and individual conferencing with
select professionals in regards to specific children and program
location.

- Help-lines for call in services such as:
  o "Watch ME Grow" in Orem through calling 211, a call in for help with
    infants, early childhood education and preschools, which was
    patterned after the Connecticut and Cincinnati programs.

  o Able program before closure provided a "warm line" consultation for
    parents and health care providers to address learning, behavioral, mental health
    and developmental concerns for special needs children for school age
    children using Salt Lake county 211 referral service.

  o IHC Phone call-in as a referral source provided by Wasatch Hospital
    started in late 2009. There are several parties outside
    IHC who have been meeting to expand this genre of support for
    Physician's and parents' consultation

  o The PAL (Partnership Access Line www.palforkids.org) system for quick time consult in
    Washington. A Massachusetts program has provided a template for psychiatry phone
    consultation for health care providers in Utah. These services are heralded by local
    medical providers.

- **Training system for Primary Care Providers**
  Physicians have requested greater support in mental health skills and knowledge as
medical schools and residency programs have not included mental health in training curriculums in
the past. Organizations as the American Academy of Pediatrics have made this a priority to facilitate
primary care providers assuming more integrated mental health care into practices. Interest supports

cost effective, online training to vision new skills, knowledge and attitudes. AAP published a CD ROM: Mental Health Tool Kit for PCP recently and evaluation of its utility in practice will remain to be seen. The Kyss Program at Arizona State University is a prototype but requires adjustment to reduce the cost.

Clinical guidelines and algorhythms are suggested here for important screening, assessment and differentiating and management of the three levels of typical case examples seen in practice including:

> **Normal variation** representing temperamentally and constitutionally derived, cases requiring better-fit universal community interventions and "common factor" strategies.
>
> **Problem definition** does not fit the criteria for diagnosis, but may demonstrate functional impairment needing intervention as RTI (response to intervention), other targeted consultations and a separate coding system for payment.
>
> **Disordered conditions** fitting a diagnosis or working diagnosis over time and may require clinical consultation, co management with possible referral or ideas or to assume care of the patient. If the condition is chronic and/or pervasive and persistent consider interdisciplinary collaboration and a coordinated team

- **Utah School-wide programs**

    The schools have heard the call to expand mental health services taking a population-based perspective (Transforming School and Mental Health Services, by Doll, B and Cummings, J.A., 2008). The Utah State Offices of Education began with the Utah Positive Behavior Initiative in many schools serving as a foundation for this collective focus group as the Utah School Based Behavioral Health which likely will continue as an interdisciplinary organization building novel ideas for school mental health services. The most recent working meeting (2010) presented a school-based survey of mental health resources by district. Although this survey was completed in the fall of 2009, sampling of individual schools would be also required with a needs assessment. School Behavior Technical Manual will soon appear on the USOE website.

    o What might be considered absolutely necessary for school mental health service standard of delivery among all schools in the state?
    o Another idea promoted is co locating mental health clinics within
      school building or co- managing school and public mental health provisions.
    o Possible expanding the age range in the group's efforts to include 0-5, adolescent and young adult transition.

- **Planning, Financing of Information systems and evaluation**
    o Grant possibilities require further discussion to be able to continue this effort. A minimal staffing for furthering these ideas is necessary to consolidate these initiatives and guarantee fluid processes. Ongoing surveys, focus groups, researching and justifying needs, high light critical current and past pertinent studies to organize substantial gains are required. Determining a data system that can be effective for justifying further efforts and means towards this proposed system of mental health care:

- Strategic planning and study group to assess feasibility to modify MH master Plan with this important early intervention, screening, assessment, promotion, prevention and risk reduction met.

- Strategic planning committee to review the Local Interagency Councils (LIC) and systems of Care (SOC) in their level of activity, function, needs and goals.

- Review a current purpose and action for renewing function of the Rapid Response Team —state agency heads for highly involved children.

- Stakeholders for strategic planning and grant partnerships to be comprised in part by such entities as:
  > *Family advocacy groups* such as NAMI, Allies, Parent center, Links/Other
  > *School/Education* Utah's School based Behavior, School Nurses, Utah Association of School Psychologists, Utah's School Health Committee Health/Prevention program/Other
  > *Health Care* as DOH and Utah AAP/AAFP chapters
  > *Mental Health* as State MH, Valley MH, State SA,
  > *Other State* as DCFS, DSPD, Utah rural and frontier representation/other

- Possible Grant, Foundation application to be determined:
  > Initial seed money potentially contributed by each agency.
  > An invitation by the National School Mental Health organization to confer with title 5, MCH and interested local providers/parents to discuss possible interagency grant. (The UCAN grant in past years has promoted strengthening of partnerships and fluidity of wrap around services.)

- Consider the merits of this proposal and its assignment to a NAMI/ Allies staff person
- Co agency Support for a DOH/Human Services (MH) presentation
- Assess outside/in state grant/foundation/other govt/private sources planning monies

APPENDIX   A   DIAGRAM

A Broader Scope of Care: Promoting Positive Mental Health
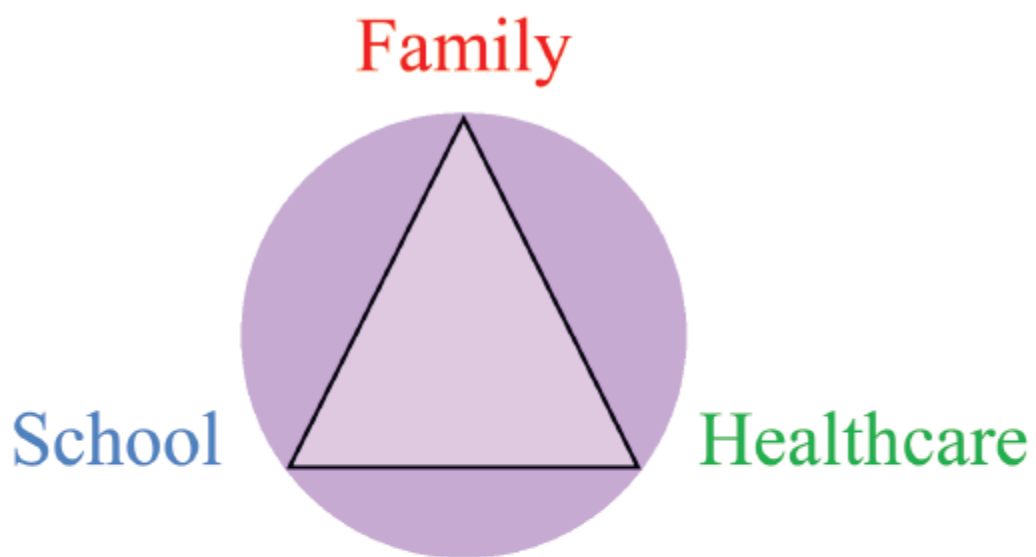
Key:
Mental health is
represented as the circle.

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