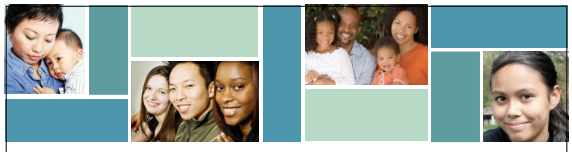

# Elevating the discussion: Creating responsive systems for serving children with mental health challenges and their families

Janice L. Cooper, Ph.D.
National Center for Children in Poverty
21st Annual Research Conference, A System of Care for Children's Mental Health: Expanding the Research Base
February 26, 2008

NCCP National Center for Children in Poverty
Columbia University
MAILMAN SCHOOL OF PUBLIC HEALTH

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## National Center for Children in Poverty

### *Who We Are*

- NCCP is a non-partisan, public interest research organization at Columbia University's Mailman School of Public Health
- NCCP uses research to promote the economic security, health, and well-being of America's low-income children and families.
- Our ultimate goal: Improved outcomes for the next generation.



## Setting the Context

- Purpose
  - Outcomes
  - Quality
  - Framework for Quality
- How are our children doing?
- How are our we doing?
- What's the evidence?
- Other Components of Quality
- Challenges and opportunities: policy levers and choices



## How are our children doing?

- **Under-use:**
  - < 20% children and youth who need mental health services receive them -- fewer children of color
- **Overuse:**
  - Despite mixed/inferior outcomes use of residential treatment still dominates service delivery
  - Ineffective treatment as usual (TAU) prevails in community-based services
- **Misuse:**
  - Missed opportunities to intervene early
  - ER, JJ, CW as de-facto community mental health



## Quality benchmarks — IOM Reports....

*To Err is Human & Crossing the Quality Chasm*

- Safety
- Effectiveness
- Patient-centeredness
- Timeliness
- Efficiency
- Equity

## Four levels of framework for improving quality (IOM)

- Patient-centered [True North]
- Care delivery unit [Micro-systemic – SOC]
- Organizational level
- Policy level



## System of Care

92% of states report that they have incorporated system of care values and principles into mechanisms such as policy, regulations, administrative procedures and contracting



## Examples include:

- MOU specific to SOC values and principles include all child-serving state agencies
- Legislation that requires implementation of SOC principles and wraparound
- Contract language that encompasses SOC principles
- Administrative code and licensing requirement references tailored care and family voice
- Legislation that requires interagency collaboration and family involvement in service delivery
- Administrative rules that require all children served through intensive case management access wraparound and families have access to flex funds
- Accreditation process includes SOC values in service contracts



## Per Berwick 10 simple rules

- Care as a continuing healing relationship
- Care individualized based on needs and values
- Family/youth as director of care
- Health care information *belongs* to family/youth
- Care decisions based on the best evidence regarding what works

Source: Berwick, D. M. (2002). A User's Manual for The IOM's 'Quality Chasm' Report. *Health Affairs, 21*(3), 80-90.



## Per Berwick 10 simple rules

- Safety is the responsibility of the system
- Transparency is required
- Family and youth needs anticipated
- Waste is identified and eliminated
- Collaboration demands no one professional or hierarchy of professionals have priority

Source: Berwick, D. M. (2002). A User's Manual for The IOM's 'Quality Chasm' Report. *Health Affairs, 21*(3), 80-90.



## Quality benchmarks for children

***"The optimal use of evidence to inform practice is likely to go beyond any use of evidence-based practices. It is likely to require the use of tested interventions along with additional information gathered at all levels of the service system in which care is delivered." Chambers, 2008***

- EBPs
- EHRs/IT
- Fiscal
- Workforce
- Continuous self-appraising and correction
- Family and youth choice and empowerment
- Cultural and linguistic competence
- Elimination of harmful practices
- Performance measurement (P4P)

## Defining evidence-based practices

- Empirically-supported way of doing/intervening
- Generally think of as process, tools, but also can be approach
- Narrowly focus on those that interventions that:[1]
  - Randomly assigns study participants into treatment and control group
  - Specifies the population of focus
  - Follows a manual that prescribes implementation of intervention
  - Possesses multiple outcome measures
  - Renders statistically significant differences between tx and control group
  - Replicable

[1]Source: De Los Reyes & Kazdin (2006).



## How are we doing?

Implementing evidence-based practices



## In a short time, implementation of evidence-based treatment models has spread

| Implementation Status | Multi-systemic Therapy | Therapeutic Foster Care | Other EBPs for Kids |
|---|---|---|---|
| Statewide | 1 | 12 | 9 |
| Parts of state | 17 | 8 | 6 |
| Piloting | 6 | 0 | 2 |
| Planning | 3 | 3 | 2 |
| Not implementing | 20 | 24 | 29 |

Source: NRI's State Mental Health Agency Profiles (2004). Number of states reporting=47



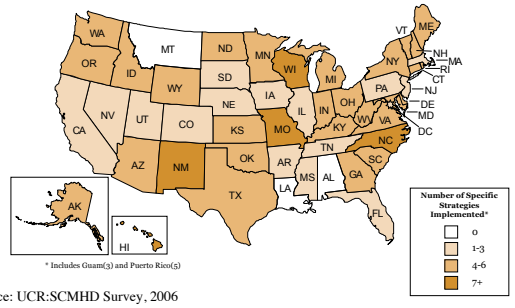
## The Role of States

**today**

All states report that they support/promote implementation of evidence-based practices in children's mental health



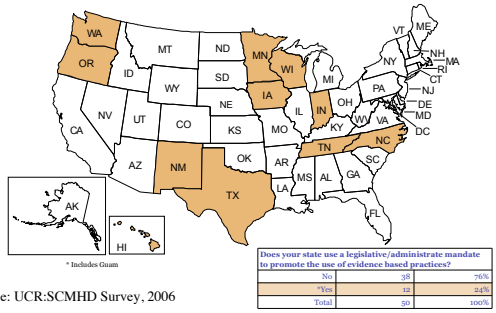
## States Implementing Specific Strategies for Promoting EBP's




Source: UCR:SCMHD Survey, 2006



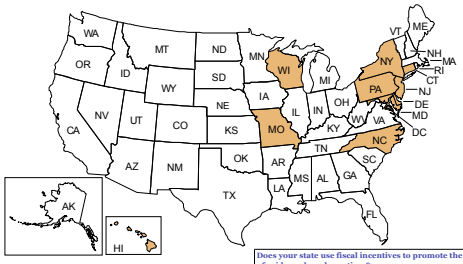
## Legislative/Administrative Mandate




| Does your state use a legislative/administrate mandate to promote the use of evidence based practices? | | |
|---|---|---|
| No | 38 | 76% |
| *Yes | 12 | 24% |
| Total | 50 | 100% |

Source: UCR:SCMHD Survey, 2006

## Fiscal Incentives

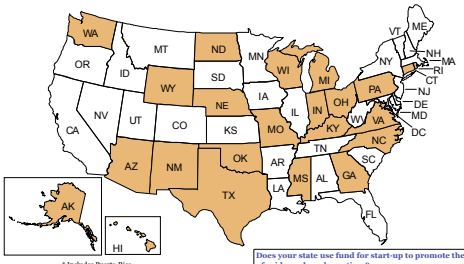



| Does your state use fiscal incentives to promote the use of evidence based practices? | | |
|---|---|---|
| No | 40 | 80% |
| Yes | 10 | 20% |
| Total | 50 | 100% |

Source: UCR:SCMHD Survey, 2006



## Funds for Start-Up



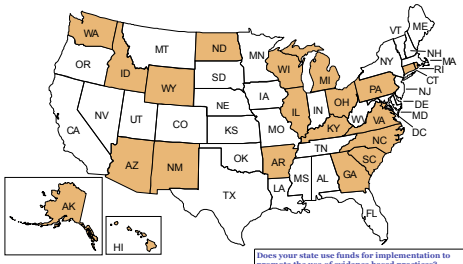

* Includes Puerto Rico

| Does your state use fund for start-up to promote the use of evidence based practices? | | |
|---|---|---|
| No | 26 | 52% |
| *Yes | 24 | 48% |
| Total | 50 | 100% |

Source: UCR:SCMHD Survey, 2006



## Funds for Implementation

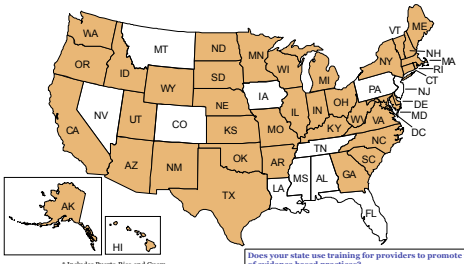



| Does your state use funds for implementation to promote the use of evidence based practices? | | |
|---|---|---|
| No | 29 | 58% |
| Yes | 21 | 42% |
| Total | 50 | 100% |

Source: UCR:SCMHD Survey, 2006



## Training for Providers



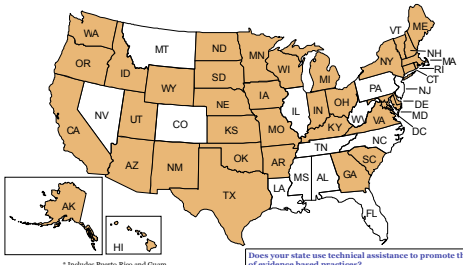

* Includes Puerto Rico and Guam

| Does your state use training for providers to promote the use of evidence based practices? | | |
|---|---|---|
| No | 8 | 16% |
| *Yes | 42 | 84% |
| Total | 50 | 100% |

Source: UCR:SCMHD Survey, 2006



## Technical Assistance



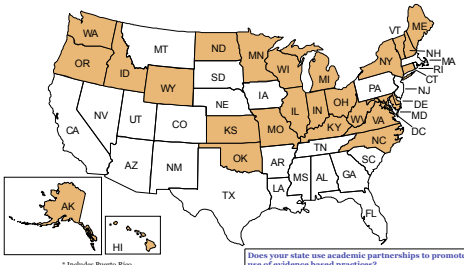

* Includes Puerto Rico and Guam

| Does your state use technical assistance to promote the use of evidence based practices? | | |
|---|---|---|
| No | 10 | 20% |
| *Yes | 40 | 80% |
| Total | 50 | 100% |

Source: UCR:SCMHD Survey, 2006



## Academic Partnerships




* Includes Puerto Rico

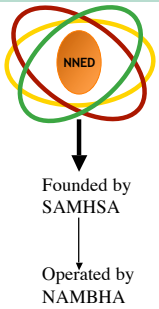
| Does your state use academic partnerships to promote the use of evidence based practices? | | |
|---|---|---|
| No | 22 | 44% |
| *Yes | 28 | 56% |
| Total | 50 | 100% |

Source: UCR:SCMHD Survey, 2006

## Public Leadership on EBPs




## National Network to Eliminate Disparities in Behavioral Healthcare [NNED]




- **A consortium of:**
  - Networks of racially, ethnic, and culturally diverse organizations
  - Knowledge discovery centers
  - National facilitation center [auspices of NAMBHA]
- **Aims to contribute to elimination of disparities through policy, practice, standards and research**
- **Areas of focus:**
  - Public education in diverse communities
  - Address workforce competence and capacity
  - Coordinate knowledge linking with communities
  - Foster integration of mental health in primary care
  - Promote culturally responsive practices
- **Funding**
  - Two behavioral health learning collaboratives



## What's the evidence?

- On child development
- On community engagement
- On race and culture
- Evidence on practices for which there is rigorous research that demonstrates repeated effectiveness



## Evidence from child development field

- Relationships matter, especially early ones
- More risk factors; poorer outcomes
- Families matter
- There are EBPs in prevention and early intervention
- Fiscal policies not supportive of a developmental frame (3rd party funding: infants, toddlers, transition service needs, includes youth aging out of the system)



## Policy implications of a risk/resilience focus

- Need to focus on risk and protective factors and intervene earlier
- Intervene seriously
- Be there for the long haul
- Focus on families



## Families paramount

- Family-based/family focused strategies and interventions should be the norm not the exception
- Strengthening supports for families
- Clear [low hanging fruit for CMH/Family and Advocacy Organizations]
  - Every identified parent with mental illness should be offered services and supports to assist with their parenting
  - Relative caregivers should be supported with services and supports for their charges and themselves
- Narrowly construed fiscal policies make it difficult to provide services for families, especially families where poor functioning contributes to poor outcomes for youth

## Communities matter

Research demonstrates that engagement strategies improve show and retention rates in mental health treatment

In one study, show rates of 60-100% resulted from using an evidence-based engagement strategy

Critical features of such a strategy included training that: helped families/community stakeholders develop problem solving skills; address race/ethnicity, language access and cultural considerations; recognize the role of poverty; prepare for initial visits; and help providers develop engagement skills.

Fiscal policy makes it difficult to create/sustain community-based services especially those that are created in the context of communities and the engagement imperative.

McKay, M. M., Hibbert, R., Hoagwood, K., Rodriguez, J., Murray, L., Legerski, J., et al. (2004). Integrating evidence-based engagement interventions into "Real World" child mental health settings. *Brief Treatment and Crisis Intervention, 4*(2), 177-186.



## Race and Culture Matter

- Children of color make up the majority of children in the public system in many communities
- Research suggests there is variability in treatment retention and engagement by race and ethnicity
- Help seeking behaviors, along with symptom expression and clinical manifestations of mental illness may vary among cultural groups
- Culturally specific treatment approaches represent unique cultural practices and beliefs, that promote cultural identity and community cohesion
- Targeted race and culture intervention strategies will ensure that disparities are addressed, and there is continued focus on closing the gap



## Where the evidence is less robust

- Families and youth of color
- Youth from poor and low income communities
- Youth with multiple disorders and multiple system involvement
- Family-based interventions



## Culturally-adapted EBPs ..... some progress

- Parent child interaction therapy (Bigfoot & McCabe)
- Trauma focused CBT (Bigfoot, Arrellano)

But the journey has just begun, long way to go:

- Review- 375+ NIMH funded clinical trials (Mak, Law, Alvidrez, Perez-Stable, 2007).
  - 50% failed to disclose complete information on race/ethnicity of participants
  - 25% failed to disclose any information on race/ethnicity
  - Under-representation all r/e groups except African-Am.
  - Understates the paucity in the children's arena



## Culturally-adapted EBPs ..... some progress

- Review of 2500+ articles published in APA journals focused on empirical clinical work reflected similar disparities for other than African-American study participants of color (Case & Smith, 2000).



## Culturally-normed EBP

- Brief strategic family therapy (Santisteban and Szapocznik)
  - Strong engagement strategies
  - DX and treatment include the family interaction
  - Context key: family/youth stressors; therapist work context

*In the works:*

- Native American Youth and Family Center (NAYA)
  - Cross & Friesen, pursuant to Oregon's mandate

## Practice-based evidence (PBE)

- Project Kofi, St. Paul, MN
  - Exceptional rates of school achievement, reduction of behavioral problems
- Community Mental Health Council (MacLean & Peoria counties) Foster Care Initiative2
  - 2 counties 50% decrease in # of AA children and youth in out-of-home placement after intervention (6X removal rates as state)
- Family navigator model
  - Family Resource Center, Richmond VA
- Native American Youth and Family Center (NAYA)
  - High rates of school achievement (graduation, school performance and attendance)
- Positive Indian Parenting program
  - 2 decade old culturally specific parenting curriculum used by AI/AN associated with high retention and consumer satisfaction

Sources: Cross, T., Friesen, B., & Maher, N. (2007). Successful strategies for improving the lives of American Indian Alaska Native youth and families. *Focal Point*, *21*(2), 10-13. Redd, J., Suggs, H., Gibbons, R., Mohammed, L., McDonald, J., & Bell, C. C. (2005). A plan to strengthen systems and reduce the number of African-American children in child welfare. *Illinois Child Welfare*, *1* & *2*, 1-12.



## Challenges: major disconnects

- Families and communities of color: lag behind in building the evidence
- Colossal failure to recognize that communities possess evidence to meaningfully contribute to development of effective practice
- Knowledge base on child development, race, ethnicity and culture largely ignored. Developers/implementers and promoters of ebps currently available must work with culturally competent developers to norm these practices for communities of color or develop appropriate practices
- Fiscal policies impede widespread adoption of current evidence-based practices: capital & cash flow; rules and regulations; proprietorship of evidence; discourages comprehensive strategies
- Have we told our partners? Health, education, justice and social services seem out of the loop



## Implications for children, youth and families of color

- Must reduce disparities [heart of pushback]:
  - Access
  - Outcomes
    - Improved mental health and functioning
    - Improved school achievement
    - More stable living arrangements
    - More permanent home environments
    - Less involvement with juvenile justice
- Requires a full-frame approach (Smyth & Goodman)

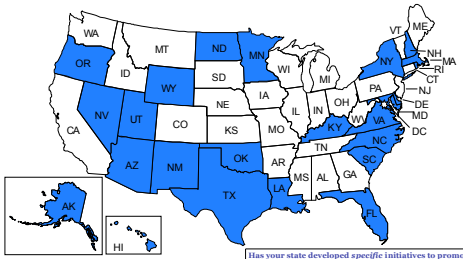


## (CM)HIT

- Importance of information technology and decision support
  - Complicated for children and youth
  - Lack of technical capacity and automation
  - Lack of infrastructure readiness
  - Software wars
- $$$ matters:
  - States lack the capital to upgrade systems and make them decision support friendly, many charts still not automated, esp. non clinical settings



## Other Components of Quality
## Electronic Records




| Has your state developed *specific* initiatives to promote the use of electronic records? | | |
|---|---|---|
| No/Unsure/Missing | 29 | 56% |
| Yes | 24 | 44% |
| Total | 53 | 100% |

Source: UCR:SCMHD Survey, 2006



## Information technology

- Providers lag behind in adopting technology
  - Psychiatrists compared to PCPs less likely to:
    - Exchange data with hospitals and labs
    - Half as likely to get information on treatment options and guidelines
    - One-fifth as likely to generate reminders on preventive services
  - Psychiatrists, compared to other MDs spec. less likely to:
    - Exchange clinical data with other specialists, hospitals, labs
    - Obtain information on treatment options and guidelines
    - Access patients' notes, medication or list of problems
    - Retrieve information on formularies

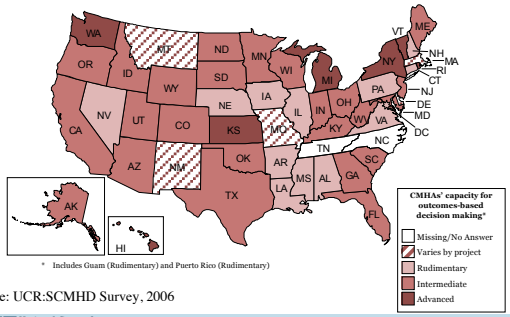
Source: Mojtabai, R. (2007). Use of information technology by psychiatrists and other medical providers. *Psychiatric Services*, *58*(10), 1261.

## A comprehensive approach, responsive to CLC and to families and developmentally appropriate

- Requires full force dissemination within and beyond children's mental health
  - Foster cross-learning between public health, primary care and mental health
  - Reduce the number of PCPs who lack confidence in intervening early and appropriately
  - Advance shared outcomes



## State Capacity for Outcomes-Focused Decision Making




* Includes Guam (Rudimentary) and Puerto Rico (Rudimentary)

Source: UCR:SCMHD Survey, 2006



## Challenges and opportunities

policy levers and choices



## Our charge: make policy relevant

- Create policy mechanisms that are:
  - Flexible
  - Responsive
  - Accountable
  - Fiscally congruent
- The problems:
  - Broad resistance to family-focused, proactive preventive policies
  - Entrenched nature of the medical model paradigm
  - Lack of will to retrain/re-craft our workforce to meet the needs of children, youth and their families
  - Inadequate attention to the widening disparities by rejecting the importance of race, ethnicity and culture



## Opportunities

- State and county leadership hungry for knowledge on effective practices
- UCR case studies reveal a myriad of strategies including designated individual at the county level for improving the knowledgebase
- Creation of centers of excellence and ebps at the state level
- Current realities demand real partnerships with communities and developing knowledge in the context of communities
- Movement from measurement of consumer satisfaction to family and youth consumer measurement of the care interaction



## For More Information, Contact:

**Janice Cooper**
jc90@columbia.edu
**Jane Knitzer**
jk340@columbia.edu

Or Visit NCCP web site

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