Strengthening Communities to Improve Child and Family Mental Health: Research Findings and Policy Implications

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The Big Problems

- Content of services vs. structures for delivery
  - Effective services exist but are not available or are not delivered effectively
- Multiple uncoordinated agencies + systems trip over each other
- Systems are passive, not proactive: Too little too late
- Families and youth seeking mental health services (unlike health services) face stigma, shame, blame

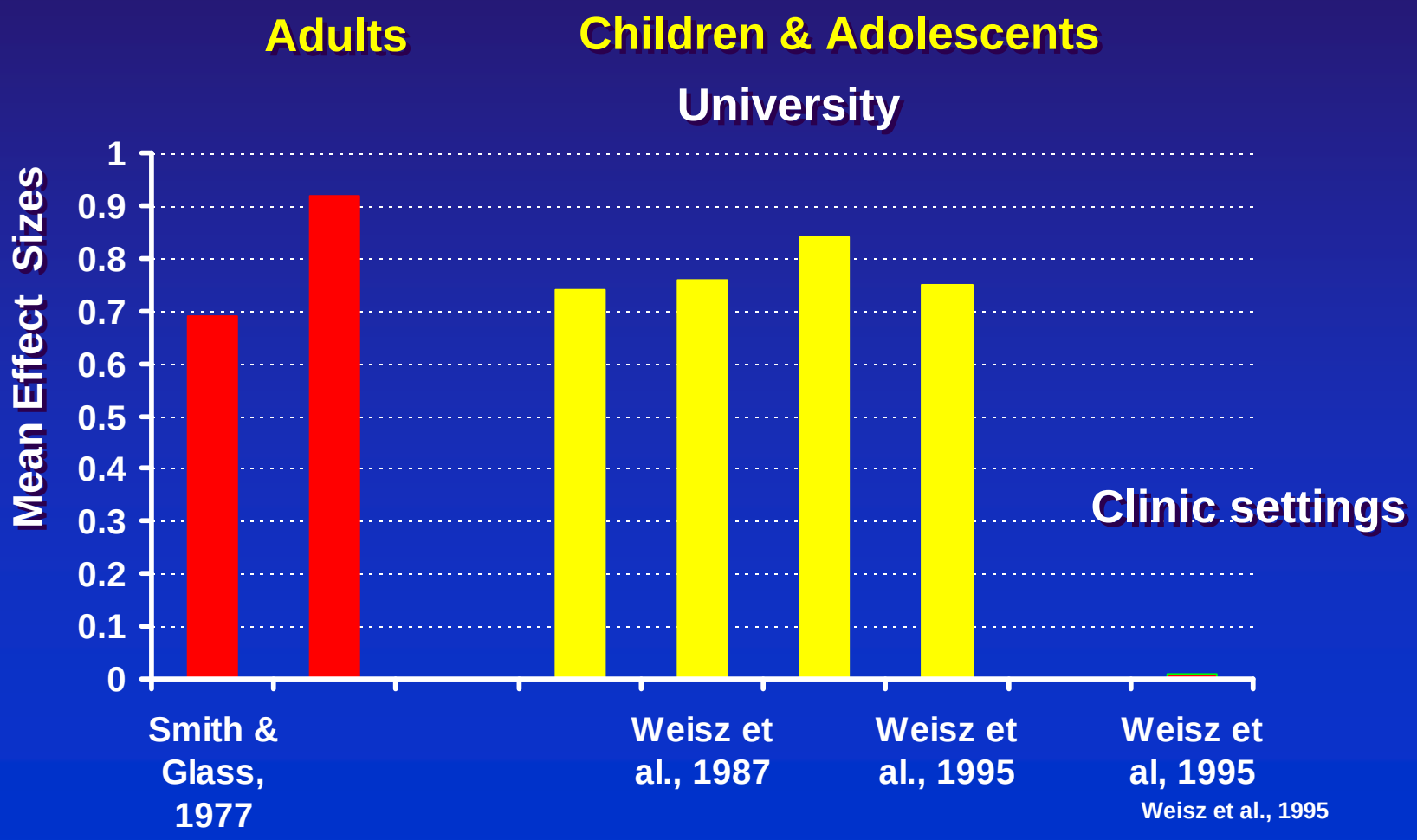
Key Points

- Research has focused on content of mental health treatments for youth, but structures of delivery remain the same as 25 years ago
- Effective (evidence-based) practices exist for both content and structure but they are not being applied
- Policies and funding priorities are heavily weighted towards **reacting** rather than **intervening** early
- Early interventions have much higher returns than other later interventions
- No change will happen if families are not fully on board: Families are the drivers of change
- Families need support, skills, knowledge to make it happen
- The child-focused system does not provide adequate supports to families
- Family to family and peer to peer community interventions that are systematic, structured, and coalition-based will transform mental health services

Brief History of Children's Services Research

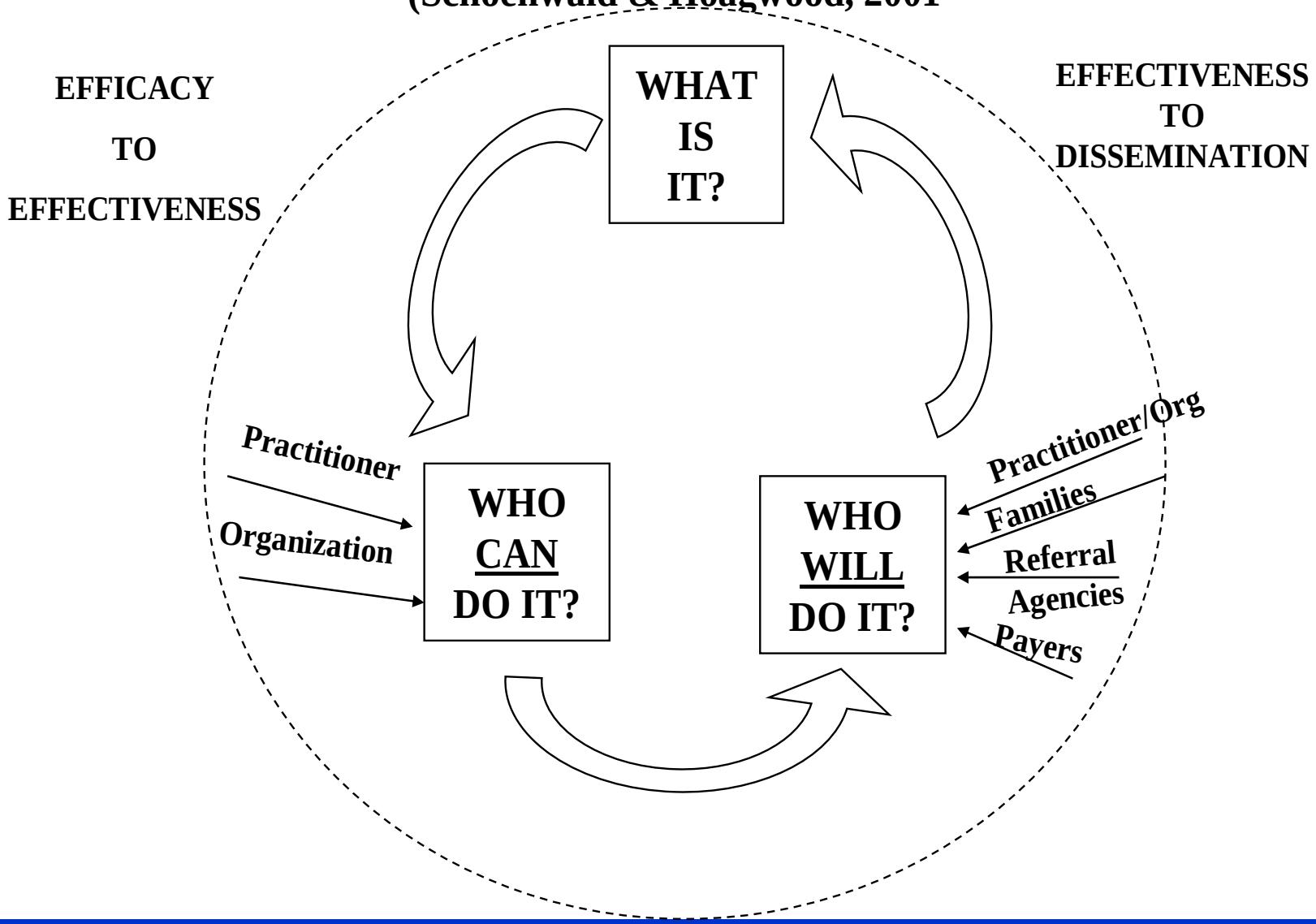
- 1982: Unclaimed Children (Knitzer) documents lack of community-based care
- 1986: Systems of Care Monograph (Stroul & Friedman) establishes principles
- 1986: CASSP federal program established
- 1989-2001: Tripling of funding for research on children's mental health at NIMH
- 1995-2003: Meta-analyses of psychotherapies for children document robust effect sizes (Kazdin; Weisz)
- 1996: System of Care study results question value of coordination (Bickman)
- 1996-present: Healthcare reform in US and Britain spurs growth of EBPs
- 1998-present: Criteria for evaluating EBPs applied to psychosocial therapies (Chambless); medication trials (Jensen); preventive interventions (Biglan; Greenberg; Webster-Stratton); services (NASMHPD's EBP Toolkits)
- 1999-2001: Surgeon General's Reports highlight disparities between research and practice
- 1999-present: Cautions about proliferation of trials without attention to therapy processes, mediators, moderators (Kazdin)
- 2002-present: Methods developed for assessing organizational context; climate found to predict child outcomes (Glisson; Schoenwald)
- 2004: Organizational interventions developed and found to improve climate, reduce staff turnover (Glisson)
- 2004-present: EBPs implementation incentivized in state and federal policies
- 2006: Family-driven services incentivized in federal policies

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



WHERE TRANSPORTABILITY QUESTIONS ARISE

(Schoenwald & Hoagwood, 2001



Increasing Community Interest in Implementing Effective Supports for Youth and Families

- 12+ State Consortium—Child and Family Evidence-based Practice (CF-EBPC) (Bruns et al, 2008):
- CA, CO, CT, HA, MD, MI, MN, NM, NY, OH, OK, PA, WA
- Effective therapies being implemented:
  - Multi-systemic therapies (MST)
  - Functional family therapy (FFT)
  - Treatment foster care (TFC)
  - Cognitive behavior therapies (CBT) for trauma
  - Cognitive behavior therapies (CBT) for depression
  - Parent management therapies (PMT)

How Effective Practices are Being Supported in Communities

- Learning collaboratives (NY)
- Outcome monitoring (MI)
- New funding targeted at specific state-wide experiments (CA)
- Single fiscal entities (NM)
- Centers of Excellence (OH)
- Clinical decision-making supports (HA, MN)
- State mandates for EBP (OR)
- State-supported EBP Dissemination Centers (NY)

Community-wide Implementation Strategies

- Community implementation of EBPs for children: CF-EBPC (Bruns & Hoagwood, 2008)
- Four strategies:
  - (1) construction of leadership coalitions;
  - (2) linkage to widely endorsed goals and values;
  - (3) development of communities of practice (learning collaboratives); and
  - (4) measurement of implementation fidelity and outcomes (Rosenheck, 2001)

Resources to Assist Communities

- Implementation Resource Guide (Toolkit) for Disruptive Behavior Disorders (SAMHSA, developed by Barbara J Burns, 2007)
- Hawaii EB Services Report (Chorpita & Dalaiden, 2007): Strength of evidence, levels, and practice elements
- MacArthur Foundation Youth Research Network (J. Weisz, et al.) ChildSteps Project
- National Registry of Effective Practices (NREP—SAMHSA)
- Journal of Child and Adolescent Psychology Special Issue on EBPs (2008)
- Institute for Healthcare Improvement (IHI) Breakthrough Series. 2003. (Available on www.IHI.org)

Consider the Fit of the Practice For Your Community

- Barbara J Burns leading toolkit development (with Lane, Rivard, Fisher) 2007
- Appropriateness for population, setting, resources, outcomes, values, expectations
- Social-Organizational issues: The social context within agencies
- Family perspectives: How are families involved and empowered? How will families become the drivers for change?

Consider the Fit: An Implementation Resource Guide on Disruptive Behavior Disorders (Burns, 2007)

INTERVENTIONS REVIEWED

- Positive Parenting Program – Level 4 (Ages 0 to 13)
- Incredible Years (Ages 2 to 9)
- Helping the Noncompliant Child (Ages 3 to 9)
- Parent-Child Interaction Therapy (PCIT) (Ages 3 to 7)
- Parent Management Training – Oregon (Ages 3 to 14)
- Brief Strategic Family Therapy (Ages 6 to 18)
- Problem-Solving Skills Training (Ages 7 to 14)
- Coping Power (Ages 9 to 12)
- Mentoring (Ages 6 to 18)
- Multisystemic Therapy (Ages 10 to 18)
- Functional Family Therapy (Ages 11 to 18)
- Adolescent Transitions Program (Ages 11 to 15)
- Multidimensional Treatment Foster Care (Ages 12 to 18)

Appropriateness of Fit

- Is study population comparable?
- Are outcomes meaningful?
- Does it fit with the agency? Intervention characteristics: setting, length, family component, who delivers, format
- Does it fit with agency resources? (training, coaching, consultation)
- Does it fit with agency monitoring and reimbursements?
- Does it fit with clinician attitudes?
- Does it fit with family expectations?

Fit with Agency Resources ? Training and Coaching/Consultation

INTERVENTION	*Is Training Provided by Developer?*	*Where is Training Provided?*	*What is Length of Training?*	*How Much Does Training Cost?*	*Is Follow-Up Coaching Available?*
Positive Parenting Program – Level 4	Yes	On-site and Regional	2-3 days with repeat in 4-6 weeks	$20,000 – 20 trainees	**Short-term**
Incredible Years	Yes	On-site, Off-site and Regional	2-3 days	$300-400 off-site $1,500/day on-site	Yes
Helping the Noncompliant Child	Yes	On-site	2 days minimum	$3,000	Yes
Parent-Child Interaction Therapy (PCIT)	Yes	Off-site	5 days	$3,000	No
Parent Management Training – Oregon	Yes	On-site	18 workshop days	$25,000 per trainee	Yes
Brief Strategic Family Therapy	Yes	On-site	4 (3-day) workshops	**$58,000 (includes coaching)**	**Yes**
Problem-Solving Skills Training	No	----	----	----	----
Coping Power	Yes	On-site	3 days	$5,000	Yes
Mentoring	No	----	----	----	----
Multisystemic Therapy	Yes	On-site and Regional	5 days for staff 2 days for supervisors	$8,000 (on-site) $750 (per person regional)	Yes
Functional Family Therapy	Yes	On-site and Off-site	3 days with 2 follow-ups	Approximately $35,000 For 3-8 therapists	Yes
Adolescent Transitions Program	Yes	On-site and Off-site	4-5 days	$4,000 (up to 20 trainees)	Yes
Multidimensional Treatment Foster Care	Yes	On-site and Off-site	5 days for staff 2 days for parents	$40-50,000 per site	Yes

Fit with Agency Monitoring and Reimbursement

INTERVENTION	*Is There a Fidelity / Adherence Measure?*	*If Yes, What is the Expectation of Use?*	*Is an Outcome Measure Specified?*	*Will Medicaid Reimburse?*
Positive Parenting Program – Level 4	Yes	Voluntary	Yes	Likely
Incredible Years	Yes	Voluntary	No	Likely (parent training)
Helping the Noncompliant Child	Yes	Voluntary	Yes	Likely
Parent-Child Interaction Therapy (PCIT)	Yes	Voluntary	Yes	Likely
Parent Management Training – Oregon	Yes	Expected	Yes	Likely
Brief Strategic Family Therapy	Yes	Required	Yes	Likely
Problem-Solving Skills Training	----	----	----	Likely
Coping Power	Yes	Voluntary	No	Likely
Mentoring	Yes	Voluntary	Yes	Not Likely
Multisystemic Therapy	Yes	Required	Yes	Likely
Functional Family Therapy	Yes	Required	Yes	Likely
Adolescent Transitions Program	Yes	Required	Yes	Likely (indicated)
Multidimensional Treatment Foster Care	Yes	Required	Yes	Likely

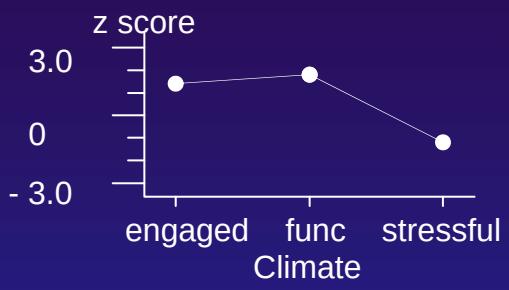
Consider the Fit: Social-Organizational Context Affects Youth Outcomes

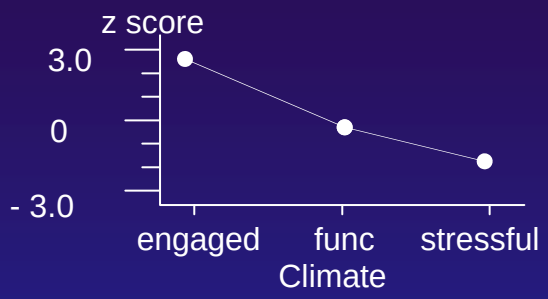
- **Context = Climate vs. Culture vs. Structure**
- **In a study of 12 counties in TN, the organizational climate of the child welfare agencies predicted youth improvement (Glisson & Hemmelgarn, 1998)**
- **Leadership factors and staff morale led to improved youth outcomes**
- **Organizational *culture* explained variations in service quality (Glisson & James, 2002)**
- **Organizational climate factors and fidelity to the treatment model affected youth outcomes (Schoenwald et al., 2003)**

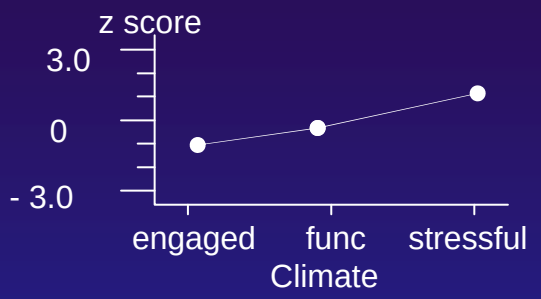
Consider the fit: Social-organizational predictors of innovation

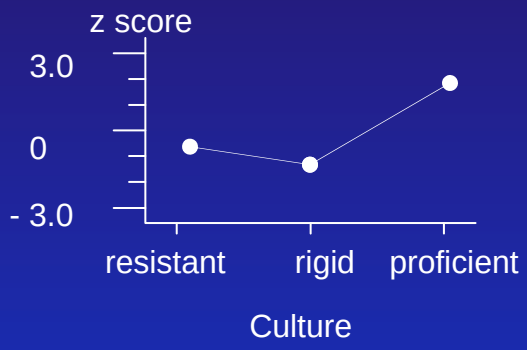
- **flexible structures**
- **strong leadership**
- **constructive cultures**
- **non-restrictive climates**
- **positive work attitudes**

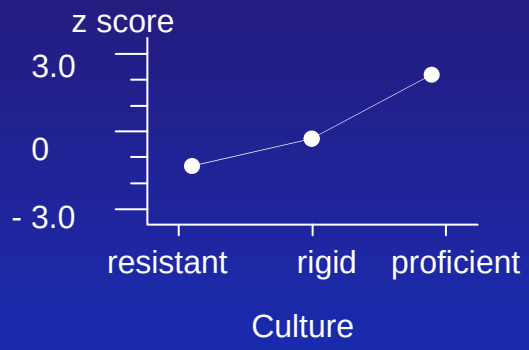
Examples of Clinic Profiles
with z scores based on National Norms (Glisson et al in press)

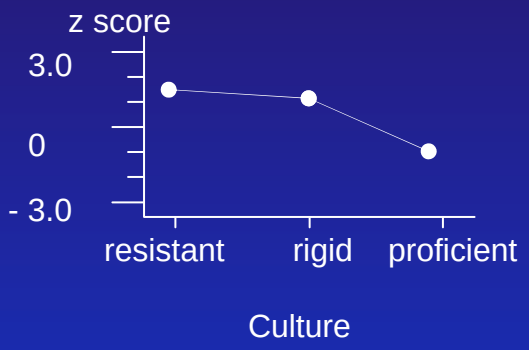












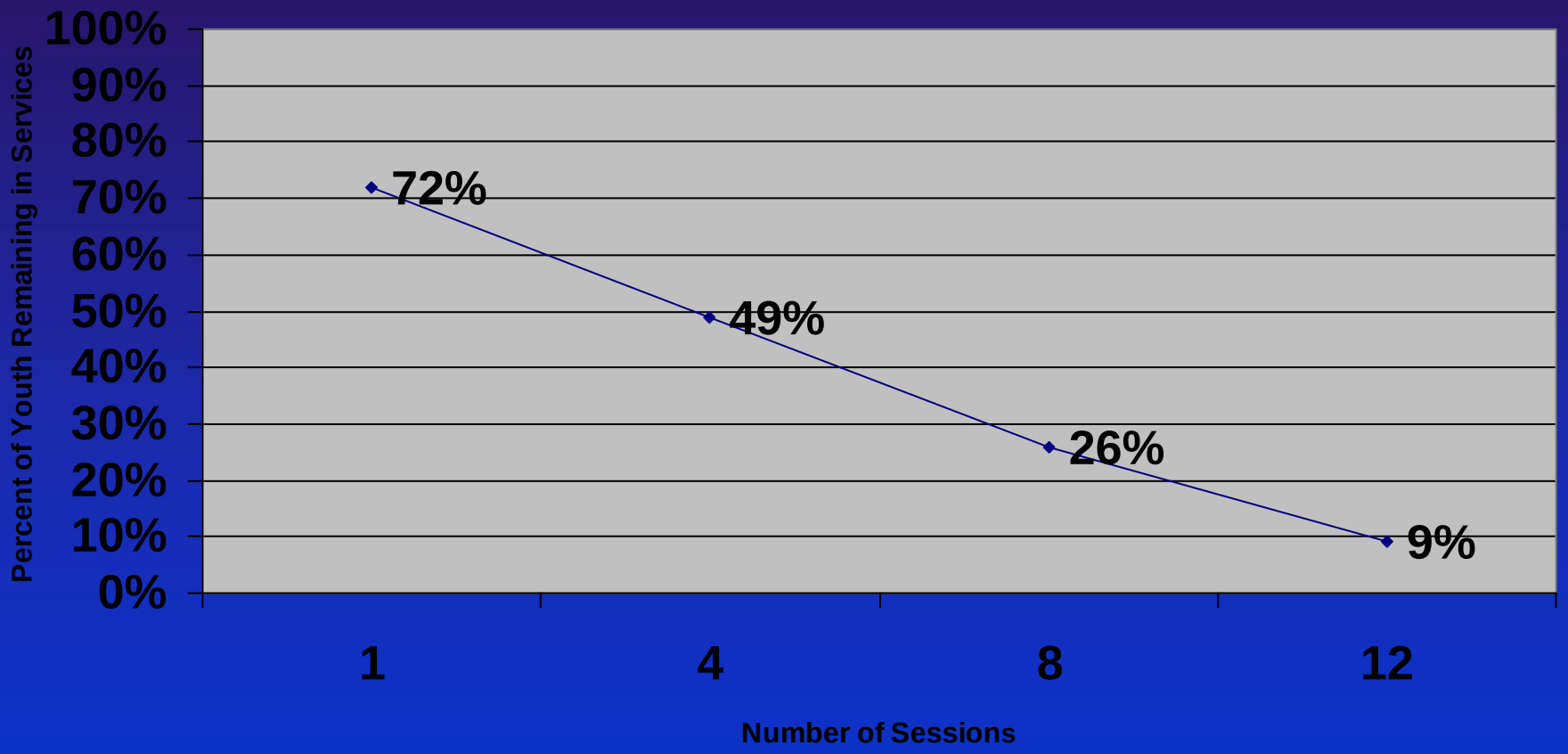
Consider the Fit: Family Perspectives:
Engagement, Empowerment, Learning Collaboratives

- What keeps families away from mental health services

- Triple threat: poverty, single parent status and stress
- Concrete obstacles: time, transportation, child care, competing priorities
- Attitudes about mental health, stigma
- Previous negative experiences with mental health or institutions

- THEREFORE:
- Rates of service use are at their lowest in low income, urban communities
- No show rates can be as high as 50%
- Drop outs usually occur after two or three sessions

Traditional Service Model



McKay et al., 2005

Evidence-based engagement interventions

- 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)

Telephone engagement strategy goals (McKay et al., 1998)

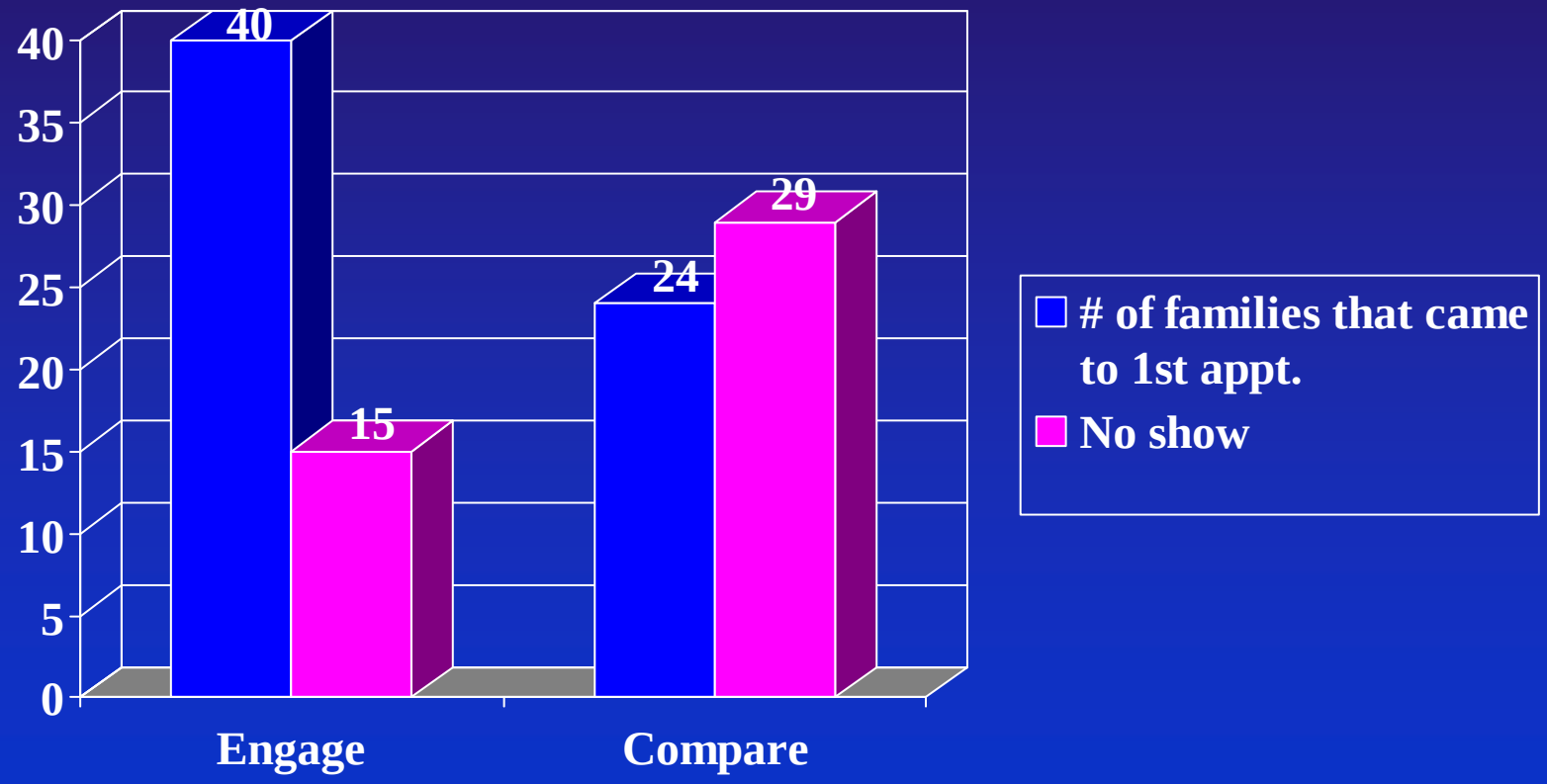
1) clarify the need for mental health care

2) increase caregiver investment

3) Identify attitudes about previous experiences with mental health care and institutions;

4) PROBLEM SOLVE! PROBLEM SOLVE! PROBLEM SOLVE! around concrete obstacles to care

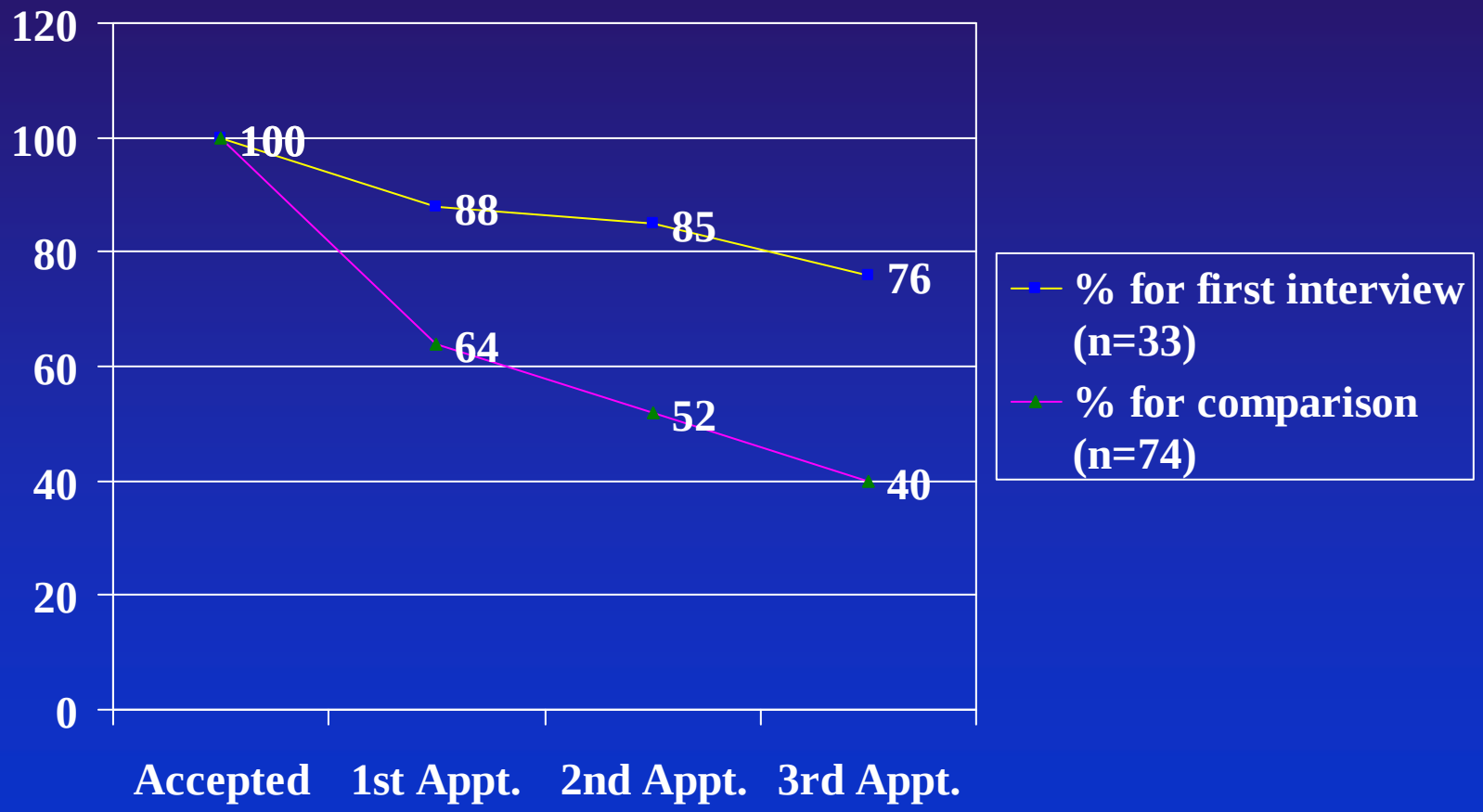
Telephone Engagement Study Results



Getting a child to a first appointment is not enough! First interviews are critical (McKay et al., 1999, 2005)

- Protocol for first/engagement interviews
  - 1) setting a comfortable tone;
  - 2) prioritizing collaboration with parents;
  - 3) focusing on practical concerns;
  - 4) problem solving barriers to next appointment.

First Interview Results



Empowering parents to become active partners

- Engagement interventions target clinic intake staff
- But for parents targeted support, education and skill building is also needed
- Empowerment interventions target family advisors/advocates who work directly with parents
- Empowerment interventions incorporate engagement strategies and focus on behavior activation for parents based on improving knowledge about services, collaborative skills, and self-efficacy

Studies of family education and support in mental health

- Improves knowledge, retention, family functioning, satisfaction with care, health outcomes, receipt of appropriate treatments (Blanchard et al., 1990; McFarland et al., 2000; Stewart et al., 1993)
- Improves self-efficacy-- active participation in decision-making (Heflinger & Bickman, 1997; Bickman et al., 1998)
- Family to family support (F2F) reduces stigma and distrust by improving communication (Linhorst & Eckert, 2003)
- Improves activation in seeking care (Alegria et al., 2008)

Parent Empowerment Program (PEP) for Professional Parent Advisors (Jensen & Hoagwood, 2008)

- PEP is a 40-hour training and consultation program for family advisors/advocates working with caregivers of youth with mental health needs
- Goals: Enhance family advisors' knowledge of:
  - Specific mental health disorders
  - Evidence-based treatments for these disorders
  - Community and school services for children
- Enhance family advisors' skills to:
  - Engage parents
  - Prioritize needs
  - Communicate and collaborate effectively with providers
- Improve youth mental health by:
  - Promoting parent/provider communication
  - Activating parents to stay involved in their child's treatment
- Theory-based targeting principles of behavior change (Jaccard et al., 2002)
- Manualized
- Evaluated: 2 pre/post evaluation; 1 RCT; 2nd RCT underway

Parent Empowerment Project (PEP) Manual Content

Parent Advisor Manual

- Introduction
- Getting Ready
- Building Engagement, Listening, and Boundary Setting Skills
- Building Your Teaching and Group Management Skills
- Developing Priority Setting Skills
- Specific Disorders and Their Treatments
- The Mental Health System of Care: What to Expect and How to Prepare
- Services and Options Through the School System
- Teaching Tools for Parent Advocates

Parent Handbook

- Introduction
- Knowing Yourself
- Knowing Your Child
- Treatment Management Skills: How to be Your Child's Case Manager
- Specific Disorders and Their Treatments
- The Mental Health System of Care: What to Expect and How to Prepare
- Services and Options Through the School System
- Helpful Tools for Parents

PEP Training Impact

- Randomized design. N=32 advisors and 124 parents (primarily low income, minority)
- Examined impact of PEP training on
  - advisors' knowledge, collaborative skills, and self-efficacy
  - parents' working alliance, self-efficacy
- Significant difference pre-post on knowledge, all skill sets and self-efficacy
- Significant difference at 6 months on advisors' teaching + group management skills
- Significant difference between parents in working alliance skills: transfer effect
- Strongest predictor of parents' working alliance: working with advisor who provided home/school visits (R^2=.61; F=.0001)
- High levels of depressive symptoms among parents (CES-D average 22.6; 2/3 above clinical cut-off)
- Heterogeneity of agency's social-organizational contexts and undervalued roles of family advisors: NEED FOR ORGANIZATIONAL INTERVENTIONS AND COMMUNITY COLLABORATIVES TO SUPPORT FAMILIES

Learning Collaboratives in NY

- Network of providers with a common felt need to change a high priority process, function, practice or outcome
- Partnership with panel of “experts” to provide needed clinical, technical and social supports
- Emphasis on rapid, practical and sustainable improvements
- Innovation and problem solving shared with and by members: build on collective strengths of members
- Use of CQI methods including the use of data and information to inform decision making and assess improvements

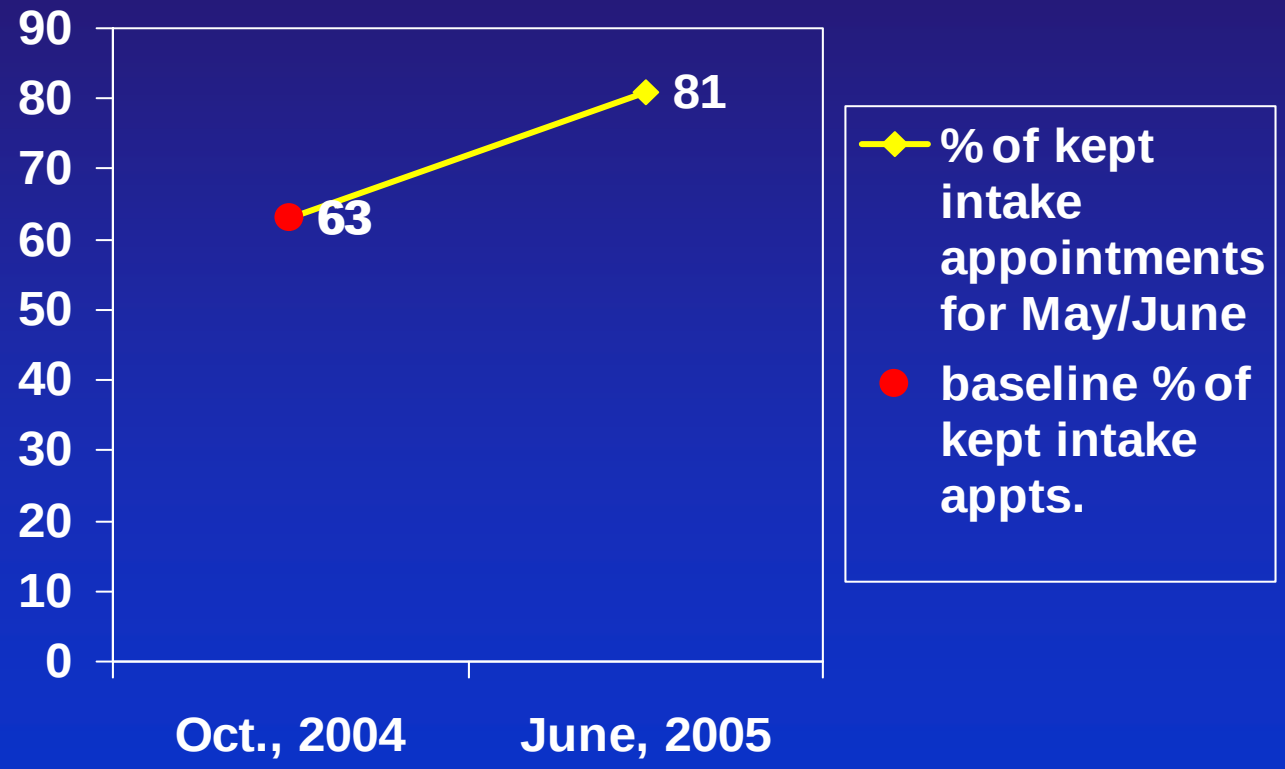
NYC Performance Indicator (McKay, Cavaleri, Bannon, Salerno)

- Show-rate for intake appointments for all new evaluations of children and adolescents
- Baseline in October, 2004
- Measured by:

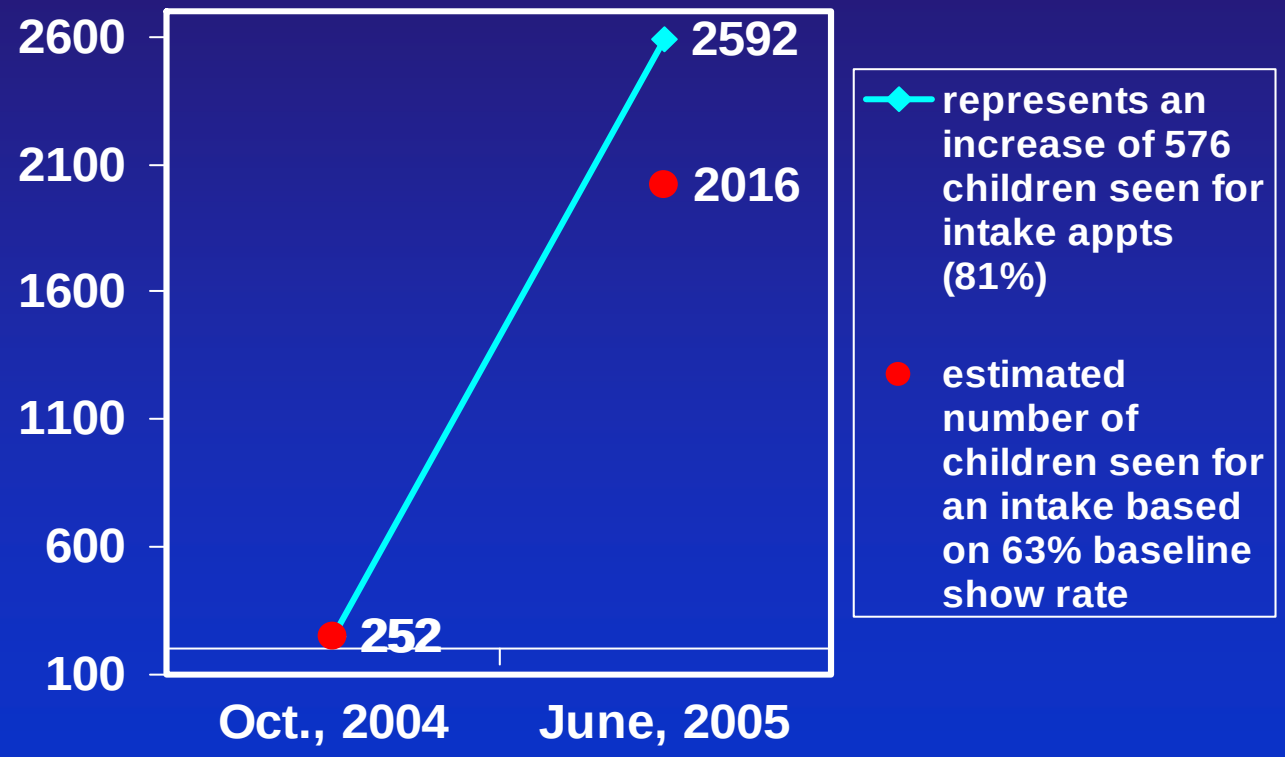
$$\frac{\text{\# kept intake appointments}}{\text{\# scheduled intake appointments}}$$

NYC Performance Indicator #1

(unweighted end point across 14 agencies)



Estimates of number of children completing an intake over time *(using unweighted endpoint rate of change across 14 agencies)*



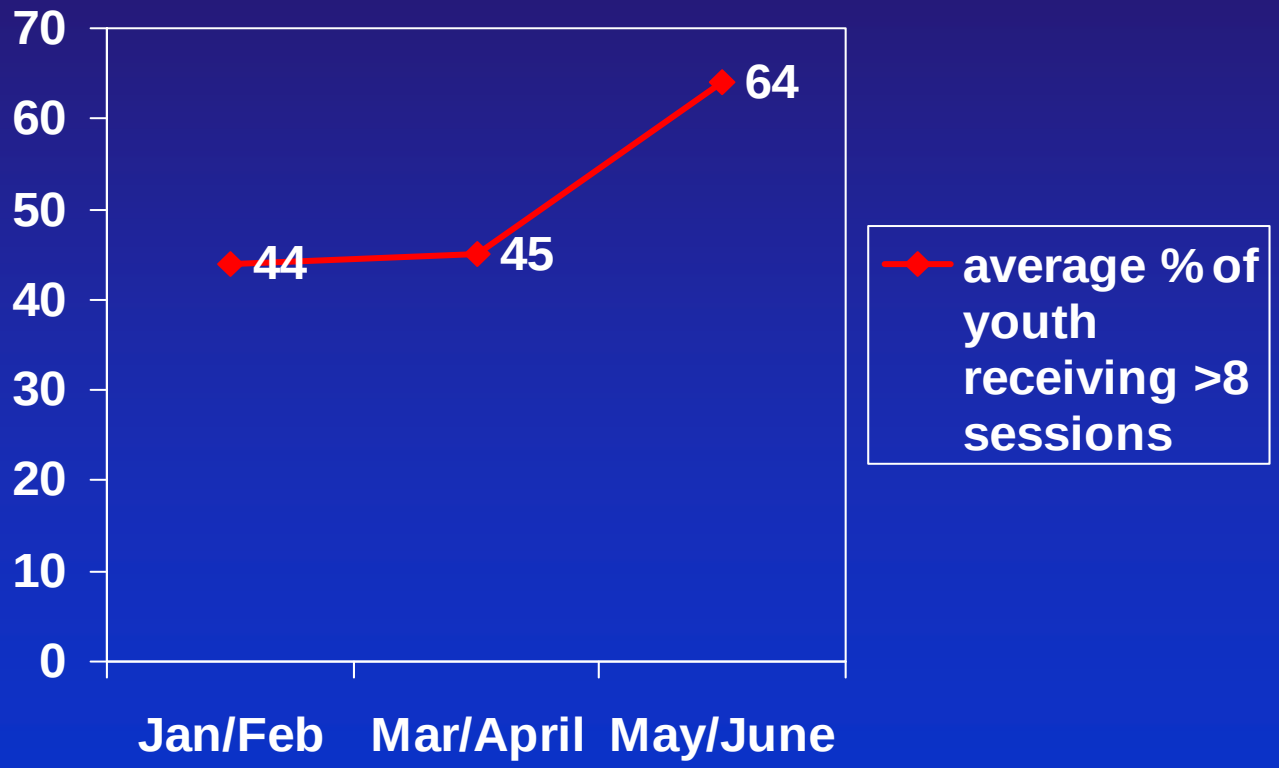
NYC Performance indicator

- Increase the total # of children who attend 8 or more clinic appointments, measured every 3 months for all new evaluations:

$$\frac{\text{\# children attending 8 or more clinic appointments}}{\text{\# children in treatment}}$$

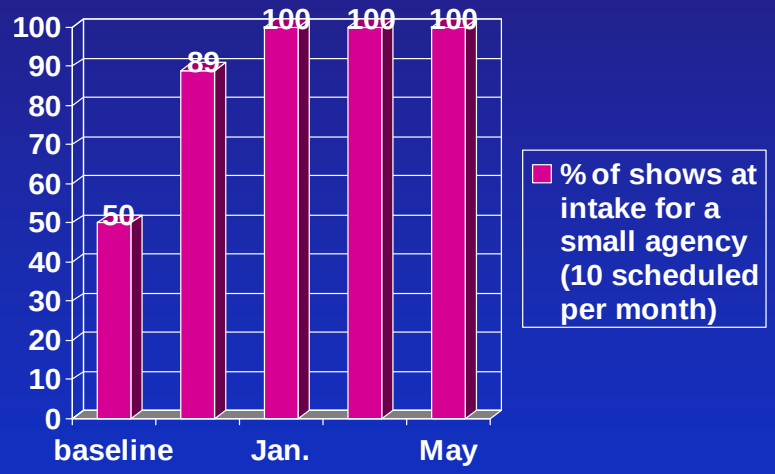
NYC Performance Indicator #3

(unweighted trend across 5 agencies)



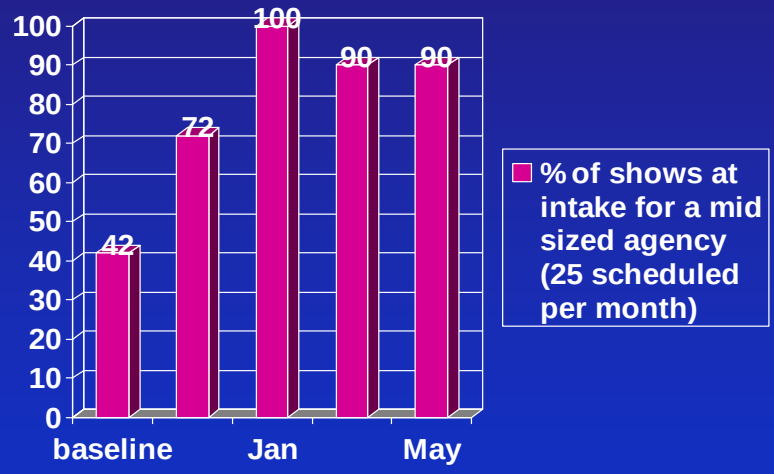
NYC Case Examples (Unintended consequences from performance indicator #1)

Agency #1



Unplanned benefits: data collection procedures are now a permanent part of clinic; data reviewed on a bi-weekly basis

Agency #2



Unplanned benefits: with this increase in productivity over the time, QI team leader argued successfully for increase in intake staff

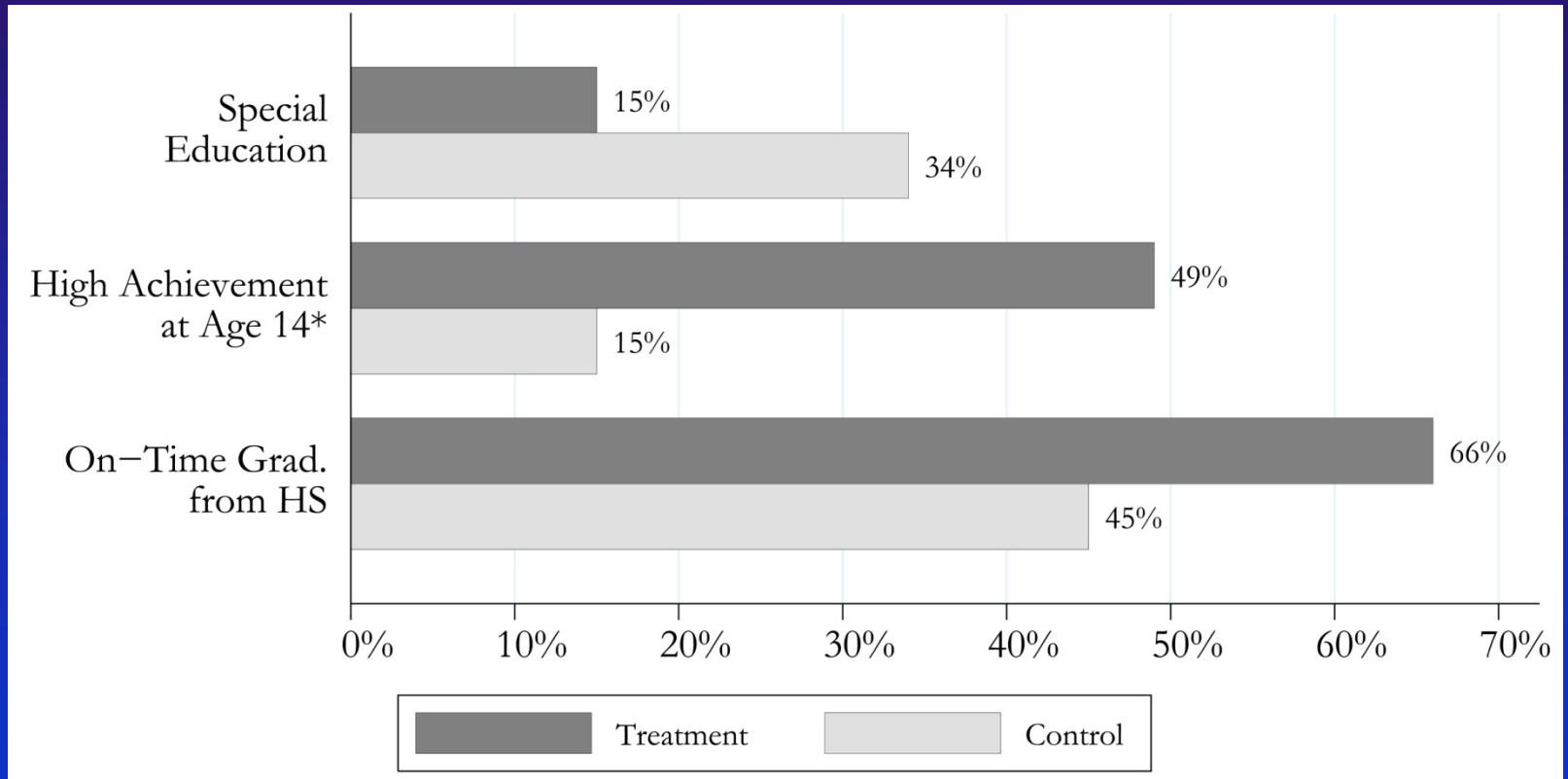
Summary

- Engagement training can reduce no show rates and improve attendance
- Engagement when linked to EBP training can improve retention in treatment
- Empowerment training can improve collaborative skills, self-efficacy, working alliances, and knowledge. It may activate change among parents.
- Learning Collaboratives can consolidate change efforts around targeted goals

Consider the Payoff: Early Intervention Programs

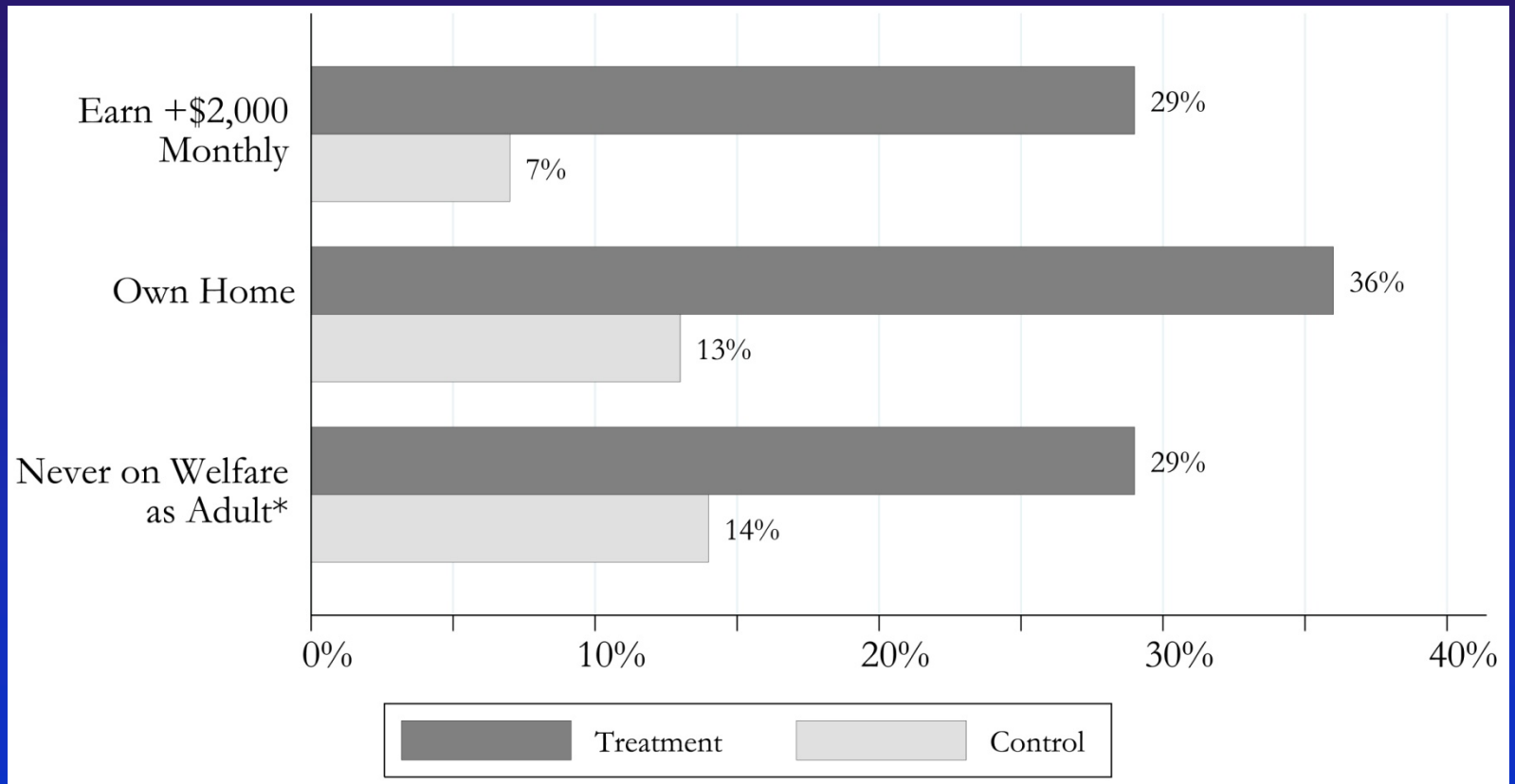
- James Heckman: Nobel prize winning economist: *Investing in Disadvantaged Young Children Is Good Economics and Good Public Policy*. National Association for the Education of Young Children, November 8, 2007
- The economic returns on early investments are high (Heckman, 2007)
- Stronger than reduced pupil-teacher ratios, public job training, convict rehabilitation programs, tuition subsidies or expenditure on police
- Children from advantaged environments by and large receive substantial early investment.
- Children from disadvantaged environments more often do not.
- There is a strong case for public support for funding interventions in early childhood.

Perry Preschool Program Educational Effects By Treatment Group (Barnett 2004)



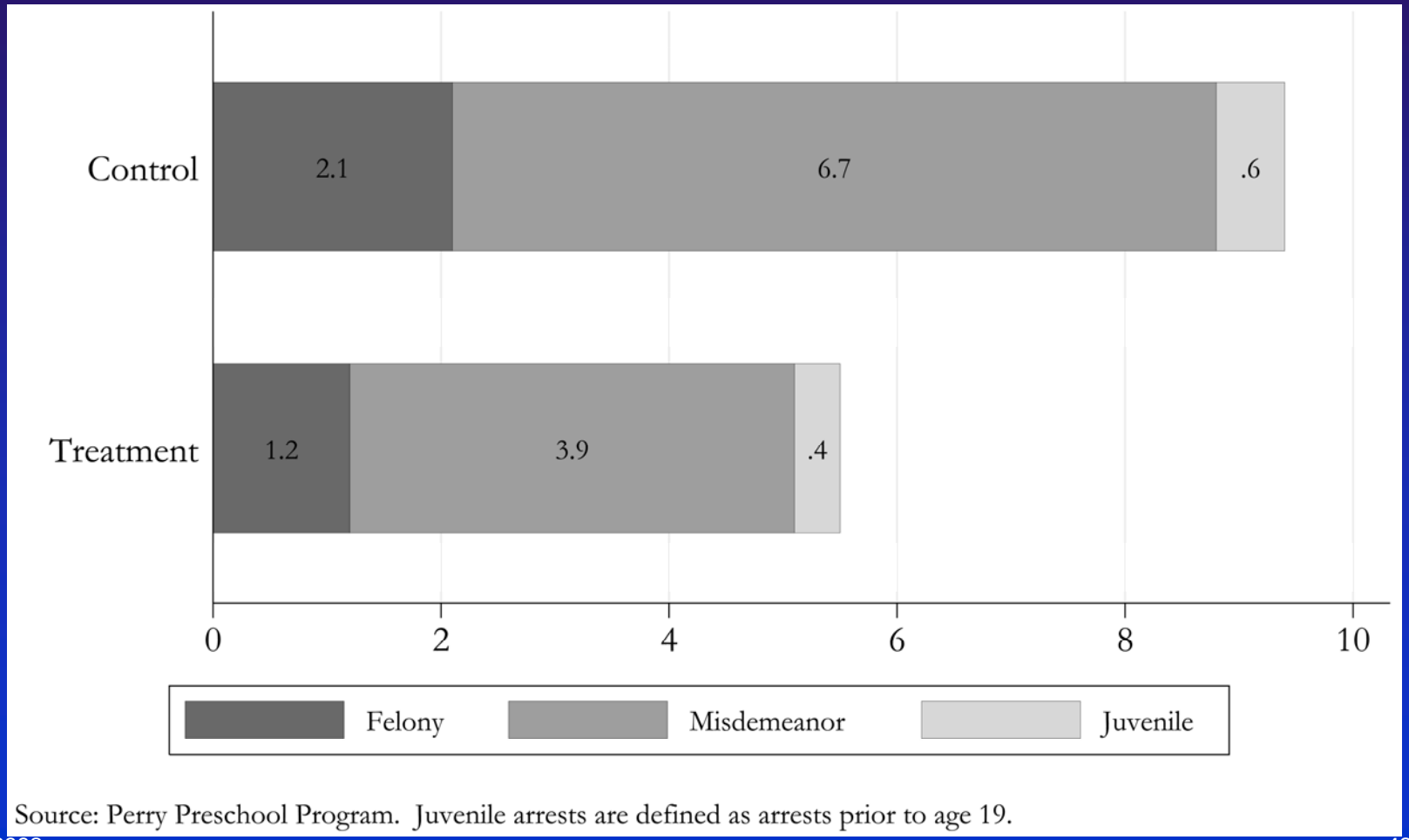
Source: Barnett (2004).
Notes: *High achievement defined as performance at or above the lowest 10th percentile on the California Achievement Test (1970).

Perry Preschool Program Economic Effects at Age 27 by treatment group (Barnett 2004)



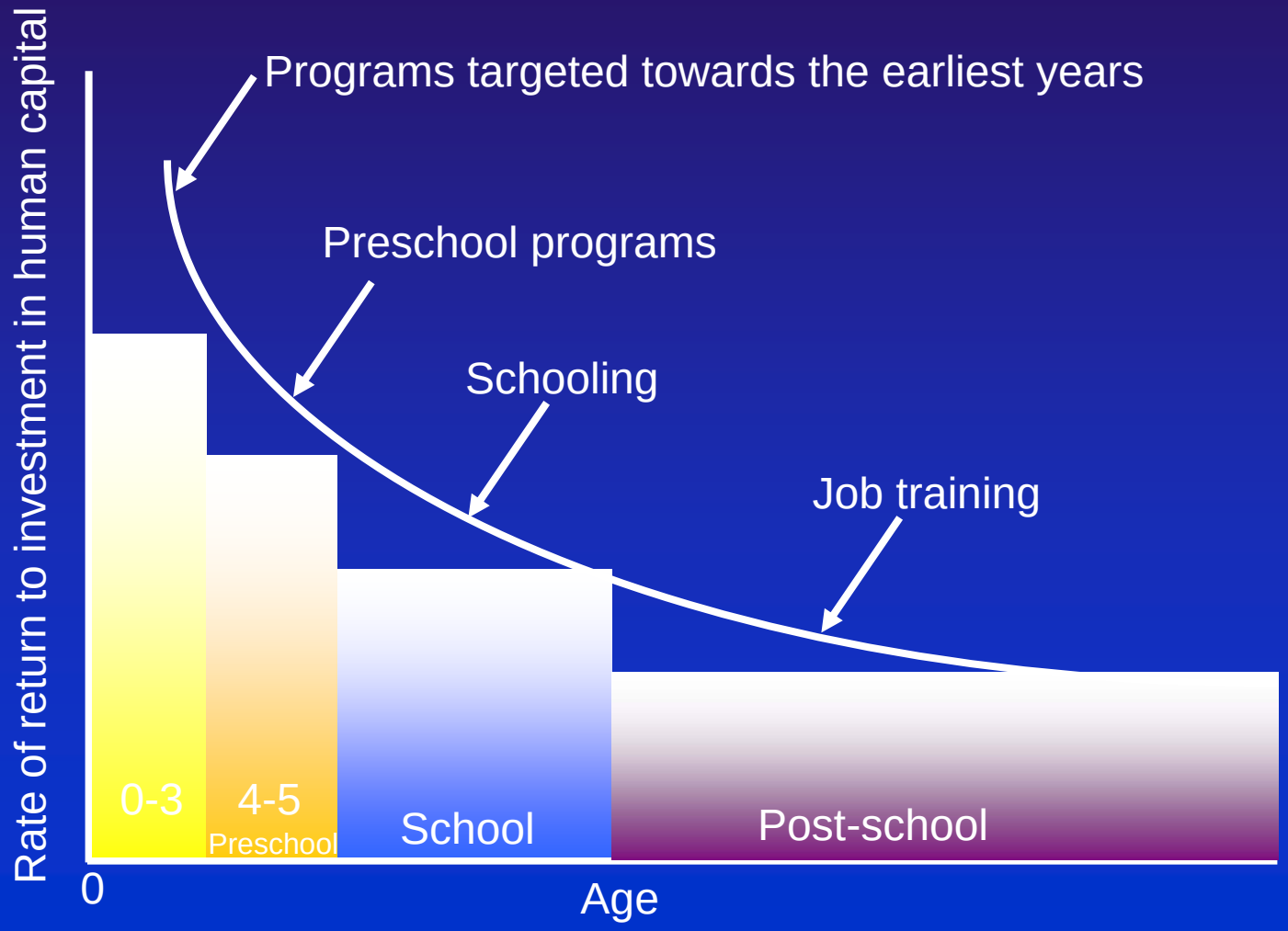
Source: Barnett (2004). *Updated through Age 40 using recent Perry Preschool Program data, derived from self−report and all available state records.

Perry Preschool Program Arrests per Person Before Age 40 by treatment group



Source: Perry Preschool Program. Juvenile arrests are defined as arrests prior to age 19.

Rates of Return to Human Capital Investment at Different Ages: Return to an Extra Dollar at Various Ages (Heckman 2007)



Closing Thoughts

- Two decades of research on effective mental health services for youth have yielded many significant findings.
  - How to screen and assess
  - How to intervene early with substantial long term gains
  - How to intervene “late” and deliver effective treatments to youth with identified problems
  - How to measure, track, and use outcome data
  - We have instruments, guidelines, protocols and other tools ready to go
- What is missing: A delivery system to get this knowledge to kids and families on their own turf.
- What will create a better system: Empowered parents and youth, knowledgeable consumers, and community coalitions organized around targeted goals