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A Public Health Approach to Children's Mental Health Services: Possible Solutions to Current Service Inadequacies

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The Child-Adolescent Mental Health Services (CAMHS) system confronts clinically complex youth with high rates of behavior problems, diverse mental health disorders, substance abuse, criminal behavior, and other “at risk” behaviors (e.g. school truancy, family conflict, etc.). Because of the complexity of the youth, the system has serious difficulties helping them to successfully overcome the myriad of problems they confront. This group proposes that a public health approach would help solve many of the inadequacies of the current system.

Public health has been variously defined; however, all definitions recognize it as the art and science of dealing with the protection and improvement of community health by organized community efforts. As such, it includes prevention, screening, and treatment, as well as environmental and social interventions. We propose that a public health approach should be taken on behalf of child mental health. Although public health is often conceptualized as focusing on physical health, we take the holistic position that “there is no health without mental health.”

A public health approach is appropriate because the strengths and problems of children and adolescents are based upon interactions between their internal genetic/biological predispositions, as well as their family, community, school, and societal environments. Through research, we are uncovering more and more evidence that all aspects of environment (intra-person, family, peer, community, and even society) are important:

- We can document the importance of the social and physical environment as a determinant of behavior and mental illnesses (Rutter 2006; McDonald and Murray 2000);
- The link between environment and human development is well-known (Leventhal and Brooks-Gunn 2003; Stiffman et al. 1999; Sampson et al. 1997);
- We have evidence that when a child or adolescent's environment is improved, some mental health problems decline (Costello et al. 2003; McKay 2005; Stiffman et al. 2007); and
- There is evidence that even the most resilient of children will succumb to a chronically stressful environment (Vanderbilt-Adriance and Shaw 2006).

A public health approach would provide an over-arching framework to integrate all arenas (health, education, social services, child welfare, juvenile justice, mental health) for interventions and services. First, it should be comprehensive in involving and integrating the arenas where the children are, rather than being confined to only the mental health arena. Second, the public health approach should be comprehensive in its scope and ideally range from health promotion through disease prevention to disease treatment. Third, the approach should be comprehensive in terms of the population and diseases targeted, including universal as well as intensive foci.

A public health approach requires an ecological understanding of mental health and mental illness. Thus, potential targets for such an approach range from the most proximal issues concerning the individual, to the more distal, starting with the family, moving outward to the community (neighborhood, housing, etc.), and finally to the sociopolitical environment which includes public policy and economics. Each of these layers of ecological features suggests different forms of interventions, and each layer confronts the reality of finite resources, opportunity costs, and social processes. At the same time each of these ecological layers suggest potential leverage points for solving issues concerning child and adolescent mental health services.

The potential of the public health approach to address the limitations of the mental health model for children and adolescents has been recognized by others. In 1961, the Joint Commission on Mental Illness and Health issued its call for mental health system transformation (Joint Commission on Mental Illness and Health 1961). This commission noted the rising demand for mental health services and recommended that public health professionals become more knowledgeable about the prevalence and spread of mental health disorders. The Surgeon General in 1999 also called for a public health approach to the outreach, prevention, screening and treatment of mental health disorders for all, and especially for populations of color. More recently, Kathryn Power, in her capacity as director of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), advocated for the development of a public health model of mental health that takes a community approach to prevention, treatment, and promotion of well-being. Two states that are recipients of Mental Health Transformation Grants from SAMHSA (Texas and Washington) have made the public health approach a core feature in their transformation (Crump 2007; Ganju 2008). Similar support for this integrative approach is also seen in the advocacy community (Blueprint for a Healthier America: Modernizing the Federal Public Health System to Focus on Prevention and Preparedness 2008; Guiding Principles for Collaboration between Mental Health and Public Health 2005; Bazelon Center for Mental Health Law 2005).

Clearly, there is a widespread recognition of the importance of a public health model as a solution to the limitations of the current CAMHS. The remainder of this paper details potential

barriers to optimal child and adolescent mental health services, and suggests potential public health oriented solutions to those barriers.

The primary barriers in mental health services are finite resources, limited policy perspectives, disjointed systems, a lack of a comprehensive multi-tiered approach, inequity in access, and failure to adopt effective interventions.

Barriers and Solutions

Barrier and Solution One: Finite Resources

The resource problems for mental health services involve two aspects: limited finances, and too few specialist providers.

Too often, financing public health approaches to mental health interventions is viewed as diverting moneys from services for individuals already diagnosed with mental illnesses. The valuation of prevention services in the short term would differ from the valuation in the long term, when prevention efforts might obviate the need for intensive expensive services. A substantial problem lies within calculating the cost and value based on short term allocations rather than long range calculations.

Regardless of how the calculation is made (short or long term), mental health services will always have limited amounts of money available. This also is true of each individual public service stream, be it education, physical health or child welfare. However, given the cost of childhood mental illness to each separate service stream, one means of addressing the issue of finite resources would be the creative use of reallocation (Frazier et al. 2007), alternative funding streams, and pooling financial resources between service systems as we reinvest in children.

Were we to provide services to all children and youth who might need them, we would quickly find that there are too few specialist providers to provide such services, and that those specialist providers are often not located in the communities with youths who are most needy. The people with the most need are least likely to be able to access/pay/use/understand/benefit from specialist treatments. Further, the very neighborhoods most likely to create children with multiple problems are those least likely to have clinical resources that can mount such services.

Two solutions are possible. The first is to move prevention services to natural settings. Then much of the lack of providers could be compensated for by local and indigenous helping networks, leaving to the specialists the most needy and complex cases. The second is to expand school based and after school programs to support and promote healthy development (Frazier et al. 2007).

Barrier and Solution Two: Limited Policy Perspectives

Much of the policy that guides mental health services is local and short term. Public mental health policy, while influenced by national policy, is greatly impacted by local politics and funding streams and is highly influenced by local mental health authorities and local government, which changes often. Local policy-makers are often unable to look critically at their own public policies, because they have no comparative information on the effectiveness of various policies, and because their continuity of leadership is interrupted by election cycles.

Examples of policy problems abound. Policies pertaining to mental health services for children and youth often tie service funding and reimbursement to diagnosis, or require the diagnosing entity (such as the school system) to provide services. Tying diagnoses to services works adequately within the mental health service sector. However, such policies can limit the

provision of auxiliary public health education, community activity, housing, or income assistance. Legislation often has the unintended consequence of requiring families burdened with these additional problems to seek services in other sectors instead of finding them bundled in a comprehensive mental health services package. Also, within the education sector, legislation requiring schools to provide services in the case of a diagnosis requires schools to financially strap themselves. Many schools find it easier to let children drop out (often to the juvenile justice system) than seek mental health services. Current policy requires that, once they identify a mental disorder, they must use their limited resources to provide whatever intensive educational help is needed. Legislation thus may unintentionally limit services.

Two approaches would help advance and broaden policy perspectives. Researchers and service providers must learn how to use legislative mechanisms to promote mental health across and between systems. To advance the impact upon legislators we must work in two directions: (1) Identify states with cross system linkages, identify what factors promoted those links, and seek technical assistance from the successful ones; and (2) Connect the dots between research data and policy in such a way that the data will be useful for and usable by policy-makers.

Barrier and Solution Three: Disjointed Systems and Departmental Silos

Despite the systems of care movement, major service systems remain largely unlinked. A public health approach would require such linkages. It would bring services out into the community as a whole and rely on public sectors (education, social service, physical health, housing, income support, juvenile justice) for implementation. We recognize that the issue of disjointed systems is intimately tied in with policy and legislation relating to both administration and funding.

To solve the issue regarding disjointed systems, we need novel programs that would link major services systems; particularly schools, with community services. Such linkages would capitalize on the capacity of local institutions to coalesce mental health services around the goals of the institution (for schools, that would be learning) (Cappella et al. 2008). The issue is in identifying such resources and then working with them on behalf of mental health services.

Many ethnic communities have community centers or religious institutions that serve as hubs for the life and well-being of the neighborhood. There are native healers, clergy, respected elders, all of whom may be potential nodes in service hubs. We should seek out indigenous resources within the various communities and involve them integrally in linking with public services for mental health promotion or intervention. Communities often have local resources that could serve as connective centers for integrated services. A public health solution would be to look to local leadership to find those who would advocate for more effective intervention. These individuals would include "Neighborhood navigators," and opinion leaders, and elders. They would not have to be mental health specialists to have an impact upon mental health services. They would have to be aware of potentially effective interventions and how to advocate for them.

Most children go to local schools, so schools would provide familiar settings for potential service hubs. Some communities have attempted such linkages, but coordinated information on their process and successes would help broaden the effect to other communities.

Barrier and Solution Four: No Comprehensive Multi-Tiered Approach to Mental Health

The issue of a comprehensive approach to mental health is tied to the barriers related to policy perspectives and disjointed systems. A comprehensive approach needs more than mere linkage. Such an approach should move from the public health arena to specialty services, beginning with health promotion, moving to screening and then to increasingly specialized mental health

services. Instead of our current single-tiered approach focusing mostly on specialty services for high end youths, a comprehensive approach would be tiered to range from health promotion through specialty services.

Mental health promotion activities would be the first step in a public health approach and could be two pronged, with each sensitive to local norms. One prong would capitalize on environments where children are found, such as schools, physical health clinics, community centers, and sports facilities. The other prong would be to seek out the families in at-risk neighborhoods through means similar to nurse home visitation, which is known to have positive long-term effects on maternal mental health problems (Olds et al. 1998).

The fully comprehensive service approach starts with health promotion and then move to a series of tiered, increasingly intensive, services. The hierarchy for the more intensive services would start with universal early screening that is then linked to the next tier of services, such as parent training, which is then linked onward in a clear ladder (Evans 2009).

Because attempts have been made to accomplish tiered systems, it would behoove us to identify successful models, and then to develop service models that capitalize on that tiering. In effect, this would be part of a comprehensive public health strategy.

Barrier and Solution Five: Inequity in Access to Services

There is notorious inequity in access to services. The issue of access has involved much research, using a number of service models or paradigms. Over the years we have tried to explain more about access by adding context for the patient, context for the provider, policy, and finances, etc. However, no iteration of the model explains the majority of variance in service access (Stiffman et al. 2004). Even with known factors predicting access, access is poorly understood and often discriminatory to poor and minority (ethnic or of color) populations.

A single door/universal portal for access to services would help diminish inequity in access. Using a public health approach we could move such a door into the public health arena. We could locate the gateway in accessible local public agencies such as schools, health clinics, and community centers. We could also use currently available data to more effectively target problems and strengths in promoting access. Federally Qualified Health Centers, (FQHC) for underserved communities, which presently are located in tribal or other indigenous organizations such as community centers, public housing agencies, and outpatient programs, and designated for primary care for Medicare and Medicaid patients, could be target agencies for such a portal. Models such as Abbottsford in Pennsylvania and Cherokee Health Center in Tennessee are both Federally Qualified Health Centers that integrate primary and behavioral health services using a public health approach and could serve as at least two systems to study when developing a portal.

Conclusions

Adopting a public health approach would give a place, within the mental health service field, for health promotion, prevention, and wellness support. The public health approach to child and adolescent mental health suggests that the very definition of treatment should embrace a broad spectrum of interventions, including health promotion, preventive interventions, and varied venues for interventions. To assist in developing a public approach to mental health services we suggest 12 action items:

1. Value the cost of mental health treatment and prevention programs from both short and long term perspectives.

2. Link the funding sources for a variety of public sectors (education, social service, physical health, housing, poverty, juvenile justice) so that mental health promotion and prevention can be served within each type of sector, as appropriate.
3. Link provider resources at different levels so as to compensate for the inadequate supply of specialty providers.
4. Actively engage in influencing legislative mechanisms.
5. Translate existing data so that it is usable by legislators.
6. Link major public service systems on behalf of child mental health in a manner that will accomplish their institutional goals.
7. Link those public service systems with local indigenous resources and leaders to develop strength-based culturally competent approaches.
8. Use local leadership to advocate for more mental health services within public service sectors.
9. Coordinate currently available data on such local linkages so as to guide others.
10. Develop a tiered approach to child mental health services that ranges from health promotion activities within public sectors through universal screening to specialty services.
11. Identify successful models for health promotion, screening activities, and tiered systems and disseminate that information.
12. Make access more equitable by developing a single door approach to entry to mental health services, and locating that “door” within local public community settings.

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