# Pediatric Community Mental Health

Lisa M. Cullins, MD, Mary Gabriel, MD, Martine Solages, MD, David Call, MD, Shalice McKnight, DO, Milangel Concepcion, MD, and Jang Cho, MD

The emotional health and wellbeing of children and adolescents and their families is of utmost importance. Pediatricians are at the front line in identifying mental illness in children and adolescents and either linking them to resources in the community or providing treatment options themselves. Collaboration and integrative health care models is the cornerstone of effective strategies to provide access and quality mental health care to children and families in communities across the country.

*Curr Probl Pediatr Adolesc Health Care 2016;46:354-388*

## Introduction: Defining the Need, Evolution and Core Attributes of Effective Pediatric Community Mental Health

Approximately one in five children in the United States suffers from a diagnosable mental disorder at an annual cost of $247 billion.[1] Overall, 70–72% of children and adolescents who are in need of treatment do not receive mental health services. Thus, the actual cost of mental health care for children and adolescents is potentially much greater. Of those who seek treatment, only one in five children use mental health specialty services. The vast majority of these children receive treatment from their primary care physicians. A child waits an average of 8–10 years between onset of symptoms and receiving treatment, primarily due to a lack of access to services. For the families that seek services, 40–50% terminate treatment prematurely secondary to lack of access, lack of transportation, financial constraints, child mental health professional shortages and stigma related to mental health disorders.[2] In sum, most children and adolescents with mental illness do not receive treatment for their symptoms. The treatment gap is even more profound for anxiety disorders and substance abuse. The gap widens even further for racial and ethnic minorities with Hispanic and African American adolescents with mood disorders in particular being less likely than their Caucasian peers to receive treatment.[3] Research has shown that without treatment, these childhood disorders may persist and lead to school failure, poor employment opportunities and poverty in adulthood, and even more tragic outcomes—suicide.

The data is even more staggering for children and adolescents who are publically insured, and/or ethnic minority youth. Presently, Medicaid is the largest payer of mental health care in the United States and disproportionately serves individuals with the most severe mental disorders. Most of the expenditure is accounted for by multiple or extended out-of-home placements not community outpatient settings.[1] Facilities that provide specialty outpatient mental health services and accept Medicaid comprise the backbone of the community-based treatment infrastructure for Medicaid enrollees.[4] However, more than a third of the counties in the US do not have any outpatient mental health facilities that accept Medicaid. Furthermore, communities with a larger percentage of residents who are Black, Hispanic, or living in a rural area are more likely to lack these facilities.[5] With the Affordable Care Act, more individuals will be able to receive access and quality mental health care as mental health and substance abuse disorders have been designated essential health benefits. It is estimated that by 2019, this type of Medicaid program expansion nationwide would double the number of persons with mental disorders who are covered by Medicaid from 12.8% to 24.5%.[4]

The potential expansion to improve access to and quality of mental health care in participating states requires an adequate supply of mental health professionals who accept Medicaid. Although the majority of

From the Children's National Medical Center, Washington, DC 20010.
Curr Probl Pediatr Adolesc Health Care 2016;46:354-388
1538-5442/$-see front matter
© 2016 Elsevier Inc. All rights reserved.
http://dx.doi.org/10.1016/j.cppeds.2016.09.001

psychiatrists practice in solo or group office settings (51%), only 3% and 8% of patient caseloads in these settings are covered by Medicaid, respectively.[4] For child and adolescent psychiatrists in particular the numbers are even more daunting. It is estimated that to meet the mental health needs of children and adolescents in the US, 30,000 child and adolescent psychiatrists are required and approximately only 9000 are present.[6] Mental health providers who participate in Medicaid tend to be concentrated in hospital and specialty community-based mental health clinic settings.[4]

The beauty and essence of pediatric community mental health is to serve children and families who are impacted the most by poverty, meager educational and employment opportunities, poor resources and violence in their communities in locations that are either close to or embedded in their neighborhoods. The impassioned spirit and charge of pediatric community mental health is ever present, and its significance and sense of urgency is palpable, but the infrastructure in which to implement and deliver services is fragile and unstable and gravely inadequate to meet the basic mental health needs of children and adolescents and their families.

## Evolution of a System: Community-Based Pediatric Mental Health

An important concept in the evolution of care delivery in children's mental health emerged as children's mental health was better understood, but did not resemble the modern system until the 1990s. This concept, community systems of care, reflected the emerging appreciation of the complexity of the development of children and demonstrated an attempt to address this complexity more thoroughly and thoughtfully. It was not until the last 2–3 decades; however, that this approach was formalized and resembled the current framework of care delivery. This model now represents the standard of care for public mental health services.

Coordination of services is essential for all children, but even more important for those children with severe emotional disturbances and involvement of multiple agencies. The community systems of care model, based on principals of the Child and Adolescent Service System Program (CASSP),[7] was developed to coordinate and integrate care from these different systems for children with complex mental health needs and to provide each child and their family individualized and culturally competent services within the community. The need for such coordination arose from the increasing influences of policy and advocacy that resulted in the de-institutionalization of mental health care in the 1960s. The Community Mental Health Centers (CMHC) Act of 1963[8] introduced stronger federal involvement in mental health care, responsibilities that until then were seen as mostly residing with states and, to a lesser extent, local communities. After 6 years, however, the Joint Commission on Children's Mental Health[9] found that despite this infusion of federal funding, little national attention or resource was dedicated to children and their families and that too many children were receiving grossly inadequate and inappropriate mental health services. In response, the CMHC Act was extended in 1972, directing community mental health centers to expand their responsibilities to include services for children. After 10 years, however, a study published by the Children's Defense Fund documented that children with serious mental and emotional disorders were receiving care that was fragmented, uncoordinated, and largely ineffective, often in institutions far from their homes.[10] Such findings prompted the National Institutes of Mental Health to establish the CASSP in 1984, heralding the inception of what is now known as community systems of care. Two more milestones set the stage for CASSP: the President's Commission on Mental Health in 1978,[11] which helped children and adolescents with severe emotional disturbances become designated as a priority service population; and the Alcohol, Drug Abuse, and Mental Health Block Grant program[12] in the 1980s instituting joint federal and state funding with a formula stipulating that 25% of funding be dedicated to children and adolescents.

Changes in service design and delivery were required once the framework was developed. Multiple demonstration projects were initiated to restructure care delivery and actualize the principles on which the framework was founded. Five pilot programs were launched in Ventura County, California,[13] Alaska, Vermont,[14] the Fort Bragg Demonstration Project, and the Robert Wood Johnson/Mental Health Services Program for Youth (eight sites). The aims of these programs were to implement CASSP ideals, reduce out-of-home placements, reduce service fragmentation, and promote earlier mental health intervention to reduce functional morbidity. Modern health economics now reinforces the goal of preserving children in their

Download English Version:

https://daneshyari.com/en/article/5717958

Download Persian Version:

https://daneshyari.com/article/5717958

Daneshyari.com