From the Child Guidance Movement to Evidence-Based Practice: Evolution or Revolution?

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What Drives Accessible and Effective Mental Health Services for Children and Families?

Leadership/Policy  

Practice Model  

Science
How the “Kids System” Works Now

Children’s Services in Los Angeles County
Child Mental Health Service Movements

Child Guidance Movement

Community Health Centers

Child Mental Health Service Movements

1920s

Community Mental Health Centers

1960s

Community Health Centers

1960s

Community Health Centers

1980s

System of Care

1990s

Evidence-Based Practice

2010s

Affordable Care Act

1920s

Evidence-
“Those who don’t study history are doomed to repeat it. Yet those who _do_ study history are doomed to stand by helplessly while everyone else repeats it.”

Anton Loeb
Early 20th Century children seen as miniature adults

Pre-WW II: Reform society for the benefit of the child

Post-WW II: Reform the child for the benefit of society
Leadership/Policy

Decennial White House Conferences on Children
Commonwealth Fund and Rockefeller Foundations 1922-1946:
8 clinics in 1922, 43 by 1930, 350 after WW II
NIMH to “train, provide services, and conduct research” (1949)

Science

Children’s Bureau (1912)
Child Development Society for Research in Child Development (1933)

Practice Model

William Healy, MD, neurologist – first court clinic 1909
Child clinics in courts, children’s hospitals, later in mental health centers

“Holy Trinity” – MD, PhD, and MSW
Psychodynamic – “child behavior a symptom of parent-child conflict” (mother-blaming)

Vision

Reduce need for mental hospitals and prisons
Prevent delinquency (maladjustment), internalizing problems later
Child Guidance Movement
(1920s – present)

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Successes

> Centers of research and treatment

> Developmental psychology applied to child welfare reform and child rearing

> Noted child guidance clinics survive with current focus on severe disorders

Challenges

> Reduced need for mental hospitals and prisons not achieved

> “Mother-Blaming” still an issue, improving with “family-centered” and then “family-driven” mandate
Child Guidance Movement
(1920s – present)

VISION

Leadership/
Policy

Practice
Model

Science
Community Health Centers (1960s – present)

VISION

Comprehensive, continuous, and coordinated quality health care for low income or uninsured families with community ownership

Leadership/Policy

Roots in antipoverty, civil rights, and social psychiatry

Continuous federal leadership and fiscal support (OEO, HRSA), Medicaid (1964)

Practice Model

Fully integrated team -- primary care, mental health, other specialists, e.g., nutrition, dental, later NPs and PAs

Screening, assessment, prevention, treatment, community consultation

Science

Health services research
Successes

- Increased detection by primary care
- Decreased stigma
- Increased access to mental health services
- Increased continuity of care
- Decreased Emergency Department use
- Medicaid savings
- Continuous federal fiscal support – mental health services in most
  - 748 in 2001
  - 1,067 in 2007
  - 1,250 with 8,000 sites serving 18 million in 2012
- Projections for 2015: 44 million for $2.6 billion

Community Health Centers (1960s – present)

VISION

Leadership/Policy ➔ Science

Practice Model ➔ Leadership/Policy

Science ➔ Practice Model
Community Mental Health Centers (1960s – present)

**VISION**

“With new medications, adequate care will be available for virtually all patients with mental illness; and mental illness would be preventable by early treatment.”

**Leadership/Policy**

1961 Joint Commission on Mental Health
1963 CMHC Act for construction – President Kennedy
1965 Staffing grants
1967 Support for services
1969 Joint Commission on Mental Health of Children
1972 Child services added (terminated in 1974)
1981 Block grants to states
1986 Medicaid allowed
1990s Privatization and managed Medicaid

**Science**

Clinical trials underway
Access and use monitored by NIMH

**Practice Model**

Separate specialty mental health serving population of 75,000-200,000
Psychodynamic
Behavior modification
Experiential
Family therapy
Community consultation

*Community Mental Health Centers (1960s – present)*
VISION

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Community Mental Health Centers
(1960s – present)

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Community Mental Health Centers (1960s – present)

Successes

> After block grants, expansion by resource-rich states

Challenges

> Continued child unmet need (70%, 1969) spawned System of Care

> 2,000 CMHCs expected by 1980; achieved less than half

> Prevention and social reform goals dropped after Block Grants

> Time-limited, sequential, and reduced federal funding prevented national spread
Community Mental Health Centers (1960s – present)

VISION

Leadership/Policy

Practice Model

Science
“The basic human resources of our land, our children, must have our highest national priority.”

Joint Commission on Mental Health of Children, 1969
System of Care (1980s – present)

VISION

“Child-centered, family-focused, community-based, multi-system, culturally competent, and in the least restrictive setting” (Stroul & Friedman, 1986)

Leadership/Policy

National Federation of Families -- 1989
Time-limited grants (SAMHSA)
-- 270 sites
-- $2.5 billion (1993-present)
Medicaid waivers

Practice Model

Services for youth with SED in a multi-system network
Continuum of care, clinical and support services coordinated by “wraparound”
Recent addition of EBPs

Science

Policy Research

Jane Knitzer (1982)
Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services

SAMHSA evaluation of model, quality, and outcomes
## System of Care

### Access and Service Use
(Sites initially funded in 2002-2006)

<table>
<thead>
<tr>
<th>Selected Services</th>
<th>(% youth) 12-24 mos.</th>
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<tbody>
<tr>
<td><strong>Treatment</strong></td>
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<tr>
<td>Individual Therapy</td>
<td>89.8%</td>
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<tr>
<td>Medication</td>
<td>77.0%</td>
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<tr>
<td>Family Therapy</td>
<td>53.7%</td>
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<tr>
<td>Inpatient</td>
<td>16.4%</td>
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<tr>
<td>Residential Treatment Center</td>
<td>14.1%</td>
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<tr>
<td>Case Management</td>
<td>83.9%</td>
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<tr>
<td><strong>Support</strong></td>
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<tr>
<td>Group home</td>
<td>4.5%</td>
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<tr>
<td>Treatment Foster Care</td>
<td>4.8%</td>
</tr>
<tr>
<td>Therapeutic Camp</td>
<td>4.1%</td>
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<tr>
<td>Day Treatment</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

(Source: SAMHSA, CMHI 2010 Annual Report to Congress)
System of Care

Successes

> 120,000 youth served

> Outcomes 0-24 mos.
  - Improved symptoms 48.7%
  - Decreased impairment 63.7%
  - Arrest (> 11+ years; prev. 6 mos.) 8.0%
  - Caregiver strain 44.8%
  - Missed work (prev. 6 mos.) 2.8 days

> Cost savings: $18 million (hospital), $6 million (arrests)
  (Source: SAMHSA, CMHI 2010 Annual Report to Congress)

Challenges

> Sustainability after federal funding
> Building a culturally and linguistically competent workforce
> Cross-agency collaboration
> Restrictive service use and lack of post-discharge care
System of Care (1980s – present)

VISION

Leadership/Policy

Science

Practice Model
Evidence-Based Practice (EBP) (1990s – present)

**VISION**

**Leadership/Policy**
- Mental Health: A Report of the Surgeon General, 1999
- APA, NAMI
- EBP Registries, guidelines, toolkits, and national trainers
- Payment for EBP (States & Medicaid)
- National Child Traumatic Stress Initiative (SAMHSA)
- Peer Parent Certification in 22 states & Medicaid

**Science**
- Epidemiology
- Prevention and Treatment Services Effectiveness
- Implementation Science

**Practice Model**
- EBPs for most Internalizing and Externalizing Disorders; Family Therapy, Common Elements, and Medication
- Support Services (wraparound, mentoring, treatment foster care)

Evidence-Based Medicine: “Integration of best research evidence with clinical expertise and patient values” (IOM, 2001)
**Evidence-Based Practice**

**Successes**

> Solid evidence for most behavioral and internalizing disorder; developing for autism, eating disorders, substance abuse, bipolar; and some for support services (therapeutic foster care, wraparound)

> EBPs added to CMHCS, SOCs, and other child service sectors

> Spread of innovative home-based services (MST, crisis, wraparound, TFC)

**Challenges**

> Initial resistance by clinicians

> Support for implementation – agency and clinician time costly

> Continued unmet need: 50% in the NHANES and 66% in the NCS-A (Mechanic, et al., 2014; Costello, et al., 2014);

> Medication prescribing high, especially antipsychotics (Olfson, et al., 2012)
Evidence-Based Practice (EBP)
(1990s – present)

VISION

Leadership/Policy

Practice Model

Science
The SOLUTION!

“Effective Interventions and Programs

+ 

Effective Implementation Practices

= 

Good Outcomes for Children, Youth, and Families”

Karen Blasé, Ph.D.
Tampa, Florida
March 6, 2007
<table>
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<th></th>
<th>EVOLUTION</th>
<th>REVOLUTION</th>
<th>DISASTER</th>
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<td><strong>VISION</strong></td>
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<td><strong>LEADERSHIP/POLICY</strong></td>
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<td>Implementation</td>
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<td><strong>PRACTICE MODEL</strong></td>
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Affordable Care Act (ACA)  
(2010s – present)

VISION

Leadership/Policy
- Advocacy by federal leadership
- Beyond parity: Mental health an essential benefit
- Integrated and coordinated health and behavioral health homes
- Preventive services and caregiver support
- Training and re-training for health professionals and peer providers

Health care for all Americans
- Shared decision-making

Practice Model
- Evidence-based practice provided and supported by finance policy and providers

Science
- Health economics
- Health services
- Future health services research:
  - Monitor access, quality implementation, and outcomes

Shared decision-making
Affordable Care Act (ACA) (2010s – present)

VISION

Leadership/Policy

Practice Model

Science
Children and families are counting on you!
Thank You!