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children's health℠

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Focus: Children's Mental Health

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Good morning Chairman Price, Vice Chairman Moody, and members of the Select Committee on Mental Health. It means a lot to people like me and the families we serve that you have given children's mental health this attention today. Families suffer quietly and this forum brings hope to many people. Thank you.

Issue

Children's health status predicts their ability to function within their family and community, both now and as adults. Their physical, developmental, and mental health interconnect and shape their ability to grow, learn, and live independently. In the U.S., child mental health is an overdue pressing need. We have clean water, kids aren't afflicted by polio, and are less likely to die from measles or meningitis. Cars don't have sharp dashboards and actually have shoulder belts in the back. In fact, as other things have improved, developmental and behavioral health disorders are top conditions causing childhood functional impairment. What weighs on me the most is that most adults with mental illness had symptoms as children and they were mostly missed.

A growing body of epidemiologic studies and science gives those of us on the front line reason to pay better attention. More children in Texas suffer from mental illness than we would otherwise expect, which speaks to the unfortunately hidden nature of these conditions. In addition, family risks we've long worried about -- domestic violence, addiction, abuse, neglect -- aren't just bad for child safety, they undermine a child's mental health and function into adulthood. These facts, as hard as they sound, give us promising direction in how to reach families and help children early on.

Selected statistics:

- 1 in 5 U.S. school-age children have symptoms that meet criteria for a mental illness
- 1 in 10 U.S. children on any given day live with a mental illness
- In Texas, more than 500,000 children and adolescents have severe emotional disturbance, a condition that impairs functioning
- 13% of TX children ages 2-7 years old have a mental, behavioral, or developmental disorder
- 1-in-3 to 1-in-5 adults have a mental illness and most had symptoms during childhood
- Children with untreated mental illness are more likely to fail school, interface with juvenile justice, engage in high risk health behaviors, and have poor health as adults
- Children with intellectual/developmental disabilities are more likely to have mental illness

- Children who live with abuse, neglect, a parent with mental illness, parent with addiction, or domestic violence, are more likely to develop mental illness in adulthood

Statistics can feel alarming, but they reveal treatable conditions and approaches, which is good news. Children are not a hidden population. We see them in lots of public settings: primary care, WIC clinics, education settings, and child welfare well before they begin to experience life-altering events or disabilities. We have many opportunities to help families and children receive evidence-based services, but we have to be ready. Our primary problem right now is that we aren't ready when we meet children in need of care.

I'll spend my time this morning describing how we've become more "ready" with other health conditions, and what I think we need to do to be "ready" with mental health. As a pediatrician, I believe we have to be as prepared for a child with symptoms of mental illness as we are for the child with breathing difficulties.

Challenge

As a primary care provider, I have three purposes: (1) to help parents keep their children healthy; (2) to identify and treat early signs of disease; (3) to get sick children immediate access to life-saving treatment.

I feel good about my ability to do this with lots of conditions: fractures, seizures, obesity, heart disease, diabetes, and asthma, to name a few. Unfortunately, I don't feel good about my ability to fully serve a family whose child has mental illness. I'd like to share an example of what I mean. Last week, in my clinic at the Rees-Jones Center for Foster Care Excellence in Dallas, I saw a toddler with poor growth for the first time, reviewed her labs and tests, noticed her developmental delays, spent 10 minutes on the telephone, and successfully hospitalized her where a specialty team took care of her; within 72 hours, she was evaluated, diagnosed, treated, discharged in good condition, and will have intensive follow-up and monitoring with me and her specialists.

The same week, I saw a school-age boy with mental illness who is facing school expulsion. I saw him three times, spent about four hours on the phone seeking services, he went to the emergency department, the family declined an outpatient medical service due to distance, and he did not follow-up despite his ongoing decline. There are many reasons for this disparity, but none of them are reasonable. From a pediatric standpoint, the school-age boy and the toddler have the exact same risk profile for health and education outcomes. But only one child received necessary care and will likely go on to live a productive life with an opportunity to achieve her full potential. One didn't and is statistically likely to be homeless.

For every condition, except mental illness, I know I can take a history, treat the child within my scope, refer for supplemental or specialty care, and my patient will receive the highest level of care he needs to survive, recover, and rehabilitate. For mental illness, one or more of these basic health care steps is delayed. Often, families have struggled to even bring up their concerns, so delays seem particularly isolating. The isolation makes finding services harder, which becomes a vicious cycle of stress and worsening health status. One family's child, who has mental illness, recently left juvenile detention after the child assaulted her mom. She left without a psychiatric

appointment and was almost out of her medication when I met them. After hours of work, we managed to get her a psychiatry appointment within a week. But within days, she had a serious mental health break at school, was arrested, and hospitalized. I did what I could and it failed miserably.

Other times, the delay is due to the family's inability to cope with the news; sometimes the delay is due to inaccurate published information regarding who is still on a health plan. All of them are avoidable. Here's how.

Potential solutions

From a health care standpoint, mental health isn't hard to address. We are finally positioned to get it right. It's the last frontier of medicine in which we need to do a substantially better job and other conditions inform us how we get there. In the 90's, when I went through medical school and residency, asthma was a disease no one wanted to diagnose. Parents hated the sound of it, we had euphemisms when we charted, and we made sure kids didn't really think they had it. But something happened. Within 10 years, we had evidence-based screening and treatment standards, quality of care indicators, practice tools, athletes proudly declaring their asthma, health plan providing incentives to provide great care, and effective home visiting programs for children who were high utilizers of costly care. I am confident the same can happen for child mental health.

Primary care practices, psychiatrists, therapists, emergency departments, school-based services, child welfare, hospitals, day treatment programs, and crisis response teams are all important services along a continuum of care for mental health. We need to better link each one so we are more prepared to serve the moment we meet a child in need. The easiest solution is integrating services, placing primary care and behavioral health in single sites so families have ready access to basic services when their child needs it. It just makes sense to place professionals together for common, distressing conditions that need early treatment. I firmly believe Texas children would greatly benefit from integrated health care. I also see additional support infrastructures that are needed in parallel.

I'd like to describe six basic and achievable health delivery components, including integrated care, that families need from front-line providers. I'm sure my colleague, Dr. Streusand, and other experts throughout the day, will emphasize those that I missed.

1. Require at least annual mental health screening during Texas Health Steps Visits:

To find kids early, we need to ask the right questions. Annual mental health screening is recommended by the American Academy of Pediatrics and adolescent depression screening is recommended by the U.S. Preventive Services Task Force. These recommendations exist for good reason. At least 1 in 5 school age children live with diagnosable mental health symptoms, along a range of mild to moderate to severe. Any condition that occurs at that frequency, has known morbidities without early intervention, and has available evidence-based interventions meets public health criteria for screening. To not look for it, risks missing children who may go on to suffer with high risk lifestyles, school failure, or develop longer term mental illness.

For the over 3 million children covered by Texas Medicaid, mental health screening is required only once between the ages of 12-17 through Texas Health Steps (THSteps). This is the same time frame most adults report childhood onset on mental illness. A once-in-four-years standard is simply inadequate. THSteps has selected several optimal tools to choose from. Requiring at least one, freely available, validated, general symptom screener at standardized, regular intervals, beginning at a younger age, would go far in catching children early.

Another area for screening improvement is screening for post-partum depression. No requirements exist currently, despite well-known risks of missing maternal depression. Research shows children of depressed mothers are more likely to suffer neglect, depression, and delays. One of my 5 month old patients entered foster care weighing less than a newborn because of mom's post-partum depression. If we don't look for symptoms early, we risk waiting until children have presented in higher cost settings, families are more stressed, and have already experienced loss or disability. Adding a post-partum depression screener to pediatric visits is overdue.

2. Develop referral networks that link non-mental health providers and parents to child mental health treatment specialists: Families need directed referrals and access to available, evidence-based, standard of care at the time of presentation or diagnosis when their child requires specialized treatments. Integrated care, the design of blending primary care and mental health in single sites, would eliminate most referral networks. Families would have access to mental health services when they first need it. Unfortunately, few practices have integrated behavioral health and primary care, which means families need simple ways to connect to specialists when primary care or emergency departments don't have capacity to treat.

The all-to-common practice of giving a parent of a mentally ill child a phone number would be considered unacceptable for any other serious condition, such as hearing deficit or diabetes. While integrated care offers a solution to many barriers to accessing timely services, children seen in non-integrated settings need referral systems for mental health treatment that mimic standards for other pediatric health conditions. Referring for serious mental illness should be as easy as referring for seizure, leukemia, or even something simple like recurring ear infections.

Every health plan has both medical and mental health professional panels. For children covered by Medicaid, "carving back in" or relinking medical and mental health practices should be a priority. Immediate access to treatment has promise of controlling morbidity and costs associated with delays in care. Helping stressed parents of seriously mentally ill children access the first appointment or immediate consultation is important. With mental illness, the margin of error due to delay can have broader consequences with learning issues, peer problems, aggression, and loss of function. Facilitating easier access to mental health care must be a priority no matter where the child presents.

3. Establish specialized service networks for children with serious or co-morbid conditions: As with any health condition, there are varying degrees of severity within the population of children with mental illness. Children with physical disabilities, developmental disabilities, autism spectrum disorders, sensory impairments, children in foster care, or those with more disabling mental illness - such as schizophrenia, severe mood disorders, and major depression -

need ready access to specialized care networks. Systems that serve children – primary care, emergency departments, hospitals, schools, and child welfare – should be equipped to link families immediately to specialists trained to de-escalate, stabilize, and treat higher needs children. Co-morbid conditions often require integrated care, given the interactions between therapies. For example, a child with autism and aggression had worsening seizures. Medication changes lead to profound weight loss and severe aggression, which would have been missed without integrated care. Finally, for children with high needs, tertiary care centers, such as residential treatment centers (RTCs) and inpatient psychiatric services, should be equipped to admit, stabilize, and manage children with psychiatric disorders who also have physical impairments, medical conditions, and disabilities. Children with diabetes or spina bifida who qualify for RTC should not be excluded due to their medical conditions. Children who live with both chronic physical and mental illness require intensive supports once they return to their communities, which seems to be lacking. I see too many children in foster care who suffer serious neglect when their parents can no longer meet their complex needs.

4. Link crisis mental health networks to first responders, emergency departments, and hospitals: First responders, emergency departments, and hospitals, who are called upon to stabilize children with dangerous or self-harming behaviors, need ready access to teams who can transition children to the most appropriate and safe continuum of care services. These services should be coordinated with the team stabilizing the child and ensure immediate continuity of care to prevent declines after discharge. Links with crisis networks could also reduce prolonged stays in emergency departments or hospital settings. It is unfortunately common for a child to seek mental health services in an emergency department, be stabilized, spend all day seeking services, only to leave without an appointment or any on-going treatment.

5. Link family support services to providers working with higher risk child populations: Texas has developed programs with the ability to respond to high-risk settings – such as abuse or domestic violence – but we miss opportunities to identify children with risk or presence of mental illness. One of my patients by age four had witnessed countless acts of domestic violence involving law enforcement at the scene. By the time I saw him, he repeatedly flashed back to scenes of seeing his mom injured. Another patient admitted to feelings of paranoia and rage, being treated for hand fractures from punching walls over seven times. His father was repeatedly arrested for criminal activity in his presence. More commonly, adults are treated for mental illness or known to be treatment non-adherent. Their children's well-being is not addressed until they, too, have obvious signs of distress.

Decades of research has identified that certain childhood risk factors are associated with developing mental illness: abuse, neglect, parent mental illness, and parent addiction. Therefore, adult service providers, child welfare, substance abuse treatment specialists, and justice systems meet children at risk. Encouraging parents to allow child screening and referrals from these settings has high potential for early treatment of childhood mental illness. I personally saw this work with a domestic violence program as it encouraged parents to seek help sooner when they saw the effects on their children. As a pediatrician caring for children in foster care, before my patients come into care, they have almost always interfaced with multiple adult systems that could help. Linking systems like health care and justice systems with family support programs will help identify high-risk children earlier.

6. Promote Integrated Care Practices: Integrated primary care, behavioral health care, and family support is a well-known, well-established health care delivery design giving individuals convenient and timely access to needed services during a single visit. Initially tested and successful with individuals struggling with addiction, integrated care has promise in mental health treatment. Bringing together primary care and mental health specialists has worked well in various pockets in Texas in small and large practice settings. I've personally developed 6 integrated clinics in various settings, including Federally Qualified Health Centers, a faith-based charity clinic, county-based medical education teaching clinics, a child advocacy center, and most recently at Children's Medical Center for children in foster care. Regardless of the population, severity, or condition, it works for expediting care and treatment. Families receive diagnosis, brief interventions, and therapies in a shared treatment environment. The difference is immediately palpable, both in the primary care provider's willingness to talk about difficult topics and a family's readiness to engage in services.

Unfortunately, integrated care is still an exception and not the norm, even for hard to reach or hard to treat populations like children in foster care. For children covered by Medicaid, integrated care provides immediate access to care, eliminates network referral delays, and serves otherwise hard to reach populations who faces barriers to seeking services. Integrated care also supports what science shows us: factors that affect mental health affect physical health. The two are intertwined in childhood in ways that require us to treat the whole child.

Conclusions

A better-designed health system will mean more immediate access to timely, evidence-based mental health treatments, interruption of decline, and protection of child and adult outcomes. Adults with mental illness rate themselves as more disabled compared to adults with physical illness and it's our job to protect children from that trajectory. A better designed system also means less reason for desperate families to feel vulnerable to costly and risky unfounded intervention, useless testing, or messages that isolate them as "bad parents." When a child has something rare, we should surely try everything. But when a child has something as common as depression, anxiety, or mood disorder, we must make sure sound and safe therapies are available, accessible, and exhausted first. It is amazing to see how therapies and medications separately or together, transform a child and family's life. One of my patients went from throwing furniture to having a great picture day at school. Another child went from running away repeatedly to showing off her report card and went on to college.

It is imperative children and families receive expert care from the moment they present. Mental illness differs from other conditions in the sheer isolation and stress experienced by families. Screening, referral networks, specialized services, family supports, and integrated health care address many of the barriers families experience on the front lines when their child is in trouble. If Texas has a network adequacy issue, it is likely related to reimbursements and payments. These barriers are real and will need to be considered as we elevate the issue of mental health to a level of importance it deserves. Linking families quickly with available and affordable evidence-based treatments protects that precious short period of time we have in childhood. Our kids are depending on us to get this right. Thank you for this opportunity and your time.