Early Childhood Mental Health and the Primary Care Setting

A Model Demonstration Program:
New York Center for Child Development and Settlement Health

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Introduction

- What is infant mental health?
- Scientific underpinnings of social emotional development
- Policy changes
- Primary care- a new direction
- Model demonstration project- Settlement Health

What is Infant Mental Health?

- It is about the formation of a secure attachment.
- It is about nurturing the ability to self regulate impulse, affect and the unfolding of self esteem.
- It is about fostering the development of the affective array.
- It is about promoting a capacity to play symbolically with imagination, feeling and creativity.
- It is about building capacity for relationships beyond the immediate attachment system.
- It is about the totality of development.

Research Foundations for Infant Mental Health

- The infant's mind is "wired" for relationships (Bowlby, 1969).
- The developing brain is plastic and a work -in-progress (Eriksson et al. 1998).
- Interactions with caregivers contribute to the developing architecture of the brain (De Bellis et al. 1999).
- Interactive relationships are intimately interlaced with and impact on all other domains of development (Provence & Lipton, 1962; Shonkoff &.Phillips, 2000).

The Scientific Background

- Neuroscientists discovered that brain scans of very young children with strong nurturing primary relationships were very different than brain scans of children with disorganized attachments to primary caregivers or of children with trauma or other stressful emotional experiences.
- It is now clear that the quality of early childhood relationships shape the child's brain architecture and have a significant impact on the ability of young children to learn, on their sensory processing, on their ability to regulate themselves and on their ability to form relationships.

Prevalence

- Between 9.5 and 14.2 percent of children between birth and 5 experience social-emotional problems that negatively impact their functioning, development and school readiness (Cooper, Masi & Vick, 2009)
- Disabilities tend to co-occur, persist and amplify over time (Ciccehetti & Hinshaw, 2002; Foley & Hochman, 2006).
- Sixty nine percent of children and youth who currently use MH services used them in the past(Costello et. Al., 1996).

Prevalence

- When environmental factors are considered (family income, maternal risk factors, domestic violence), the likelihood of mental health problems in these subsets of children doubles and triples (whtaker, Orzal & Kahn, 2006).
- Increased aggression is 19% vs. 7%; depression 27% vs. 9%; Hyperactivity 19% vs. 7%-1/3 of children in the child welfare system are in need of mental health related services (Burns, Philips, Wagner, Barth, Kolko, Campbell, et. al., 2004).

Prevalence

- Seventy five percent of adults with diagnosed MH problems reported symptom presentation in childhood or adolescence (Kessler, Berglund, Demier, Jin, Merikanags & Waltes, 2005; Weisz, 1998).
- Fewer than 1% of young children with social-emotional problems are identified (Conroy, 2004).
- Almost 55% of family practitioners and pediatricians report not administering a standardized screening tool to toddlers (Sices, Feundtner, Droter & Williams, 2003).

Prevalence

- Even when identified, 80 to 97% of young children between 3 and 5 with social emotional problems never receive a mental health service (New, Razzino, Lewin, Schlumpf & Joseph, 2002).
- It isn't until age 8 or 9 that identification and service delivery begin to rise notably and even then, mental health needs remain underserved (Zimmer & Panko, 2006)

Co-Locating Mental and Physical Health: A Rationale

- Primary health care is a central component in health care reform and a keystone to the concept of the patient-centered medical home (Rosenthal, 2008).
- The wellness orientation of routine pediatric care is a naturalistic milieu in which to introduce screening and mental health awareness because it neutralizes stigma and pathology.

Co-Locating Mental and Physical Health: A Rationale

- Pediatric services play a gatekeeper function for access to MH treatment and pediatricians are often the first professionals coming into contact with children.
- The integration of MH and pediatrics amplifies he impact of both services and enhances the rate of mental health screening and intervention.

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Co-Locating Mental and Physical Health: A Rationale

- Children who have high rates of primary care utilization are at greater risk for mental health concerns and in a sense self-refer.
- The presence of a mental health professional “in situ” increases the likelihood of mental health service delivery of some kind.

Co-Locating Mental and Physical Health: A Rationale

- Models in which a mental health specialist is integrated into a primary care setting have shown promise in improving patient and provider satisfaction, mental health accessibility and opportunities to prevent future mental health problems in children (Amenrican Academy of Pediatrics, 2009

Infant and Early-Childhood Mental Health is a Specialty

Why?

- Infants and young children are unique
- Developmental systems are notably more undifferentiated.
- Biology and psychology are more interrelated.
- Survival and psychosocial competence are relationship and family/caregiver dependent.
- Symptom presentation is different than in older children and adults

Infant and Early-Childhood Mental Health is a Specialty

- How is the discipline/practice unique?
- The practitioner must be thoroughly grounded in infant and early childhood development.
- The practitioner must recognize the interdependence and mutual influence of biological, developmental and social systems.

Infant and Early-Childhood Mental Health is a Specialty

- The practitioner must be family-centered and relationship based
- The practitioner must be transdisciplinary in perspective and team oriented
- Assessment instruments and methods of administration are unique
- Diagnostic classification systems are developmentally specific (DC:0-3R, DMIC)
- The practitioner must be versed in play-based and pre-symbolic methods of intervention

ASQ-SE

- Parents indicate whether the child does the behavior: most of the time, sometimes or rarely
- Responses are converted to point values and combined into a total score
- Children whose scores exceed the established cutoff are considered to be at-risk and should be referred for diagnostic evaluation

ASQ-SE

- Norm referenced approximating the distribution of the 2000 census data with a minimum, of 175 cases at each age level

AAP Policy Statement

- “Pediatric PCPs and other professionals who have regular contact with young children are in a key position to recognize early problems in physical, social, emotional, and mental development...”
- According to the AAP- A combination of objective screening tools and clinical judgment can increase the detection of developmental delays and lead to more effective treatment than the use of clinical judgment alone.

Nationwide Policy Changes

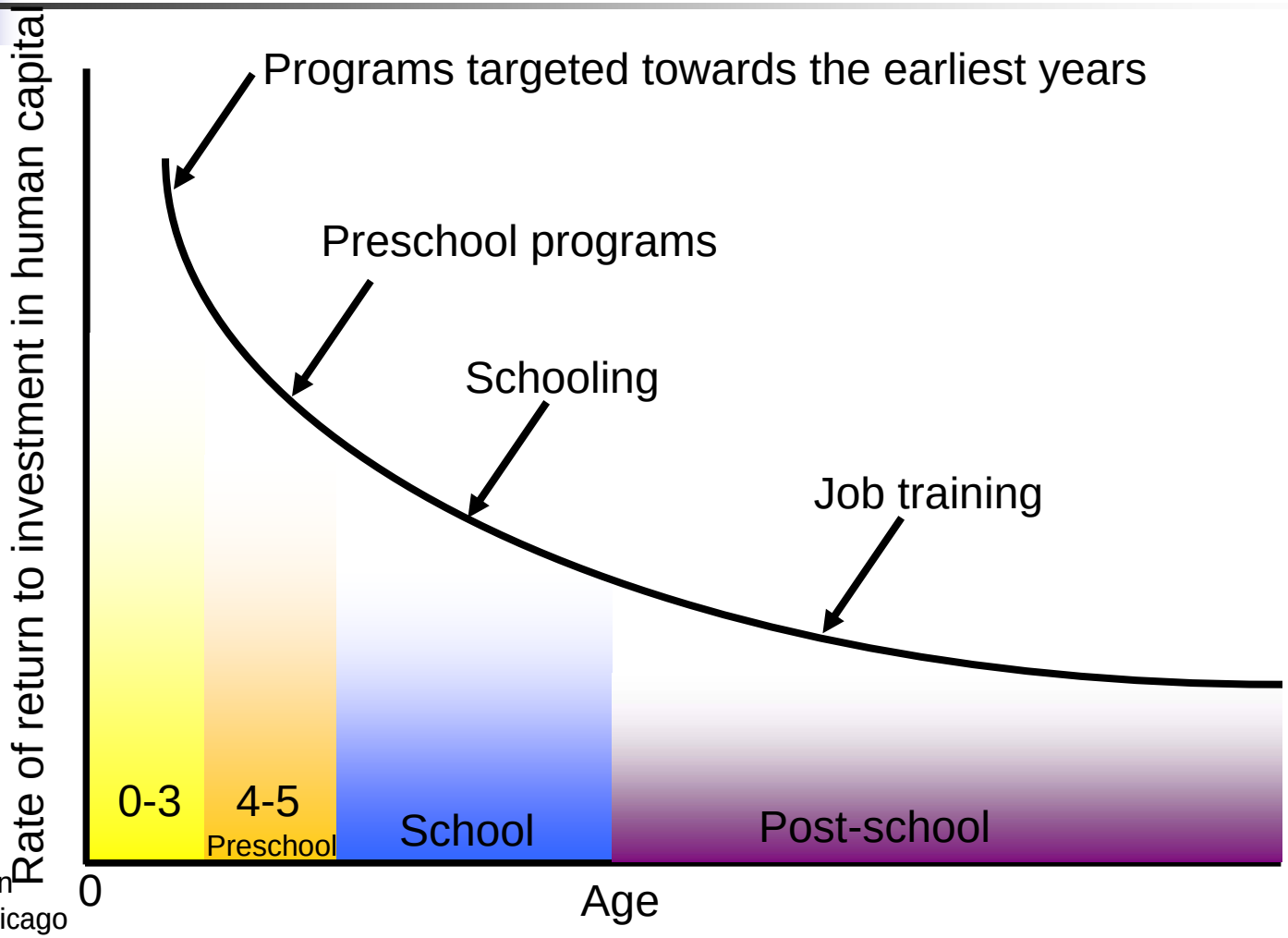
- AAP policy statement- routine screening of infants and toddlers at the 9, 18 and 30 month well child visits. They also state that early identification of developmental disorders is critical to the well-being of children and their families and is the responsibility of all pediatric practices.

- American Academy of Pediatrics 2006

The Economics of Intervening Early

- The economic returns to early investments are high.
- The returns to later interventions are much lower.
- Skill begets skill and early skill makes later skill acquisition easier.
- Most are economically inefficient.

Rates of Return to Human Capital Investment at Different Ages: Return to an Extra Dollar at Various Ages



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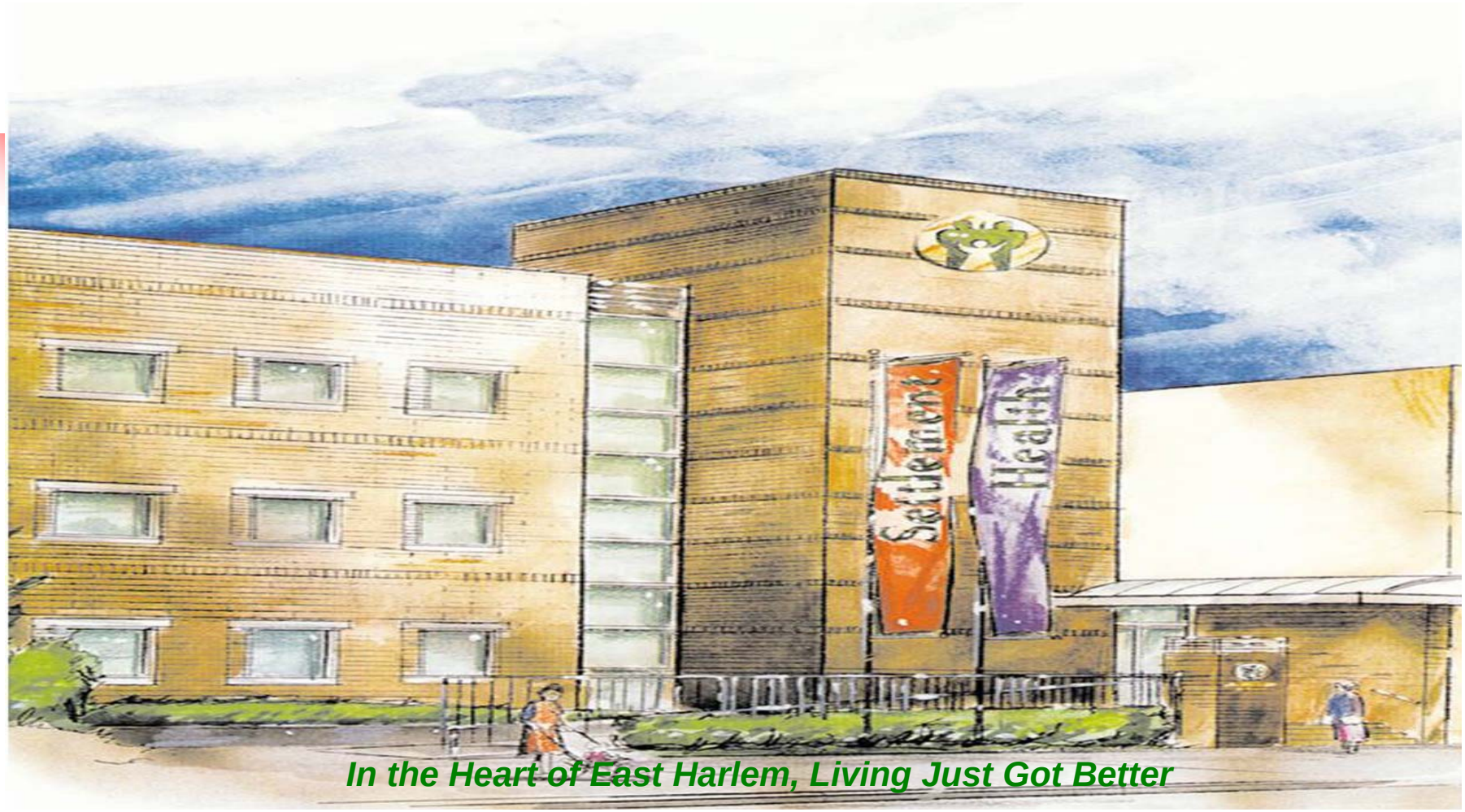
DOHMH Early Childhood Mental Health Project

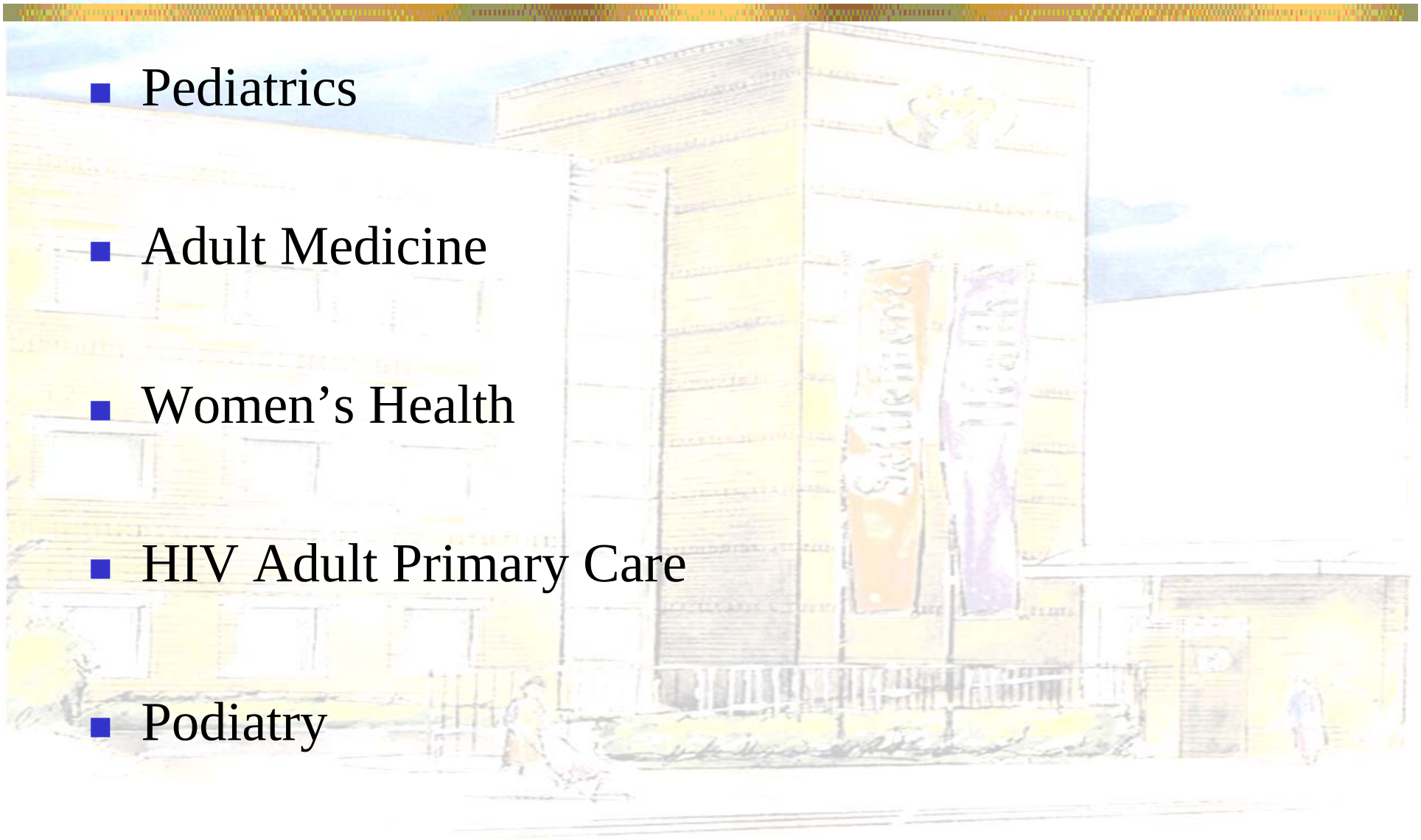
- Purpose of the grant described by DOHMH:
  - To help improve the ability of early childhood providers to prevent, identify and treat social, emotional and behavioral issues in children under 5 and their families/caregivers
  - To reduce the impact of mental health problems
- DOHMH Grant Requirements
  - Provide child and family centered consultation
  - Provide mental health consultation to staff and parents in early childhood settings

Settlement Health



In the Heart of East Harlem, Living Just Got Better

Settlement Health



- Pediatrics
- Adult Medicine
- Women's Health
- HIV Adult Primary Care
- Podiatry

Settlement Health

- **50,000 Annual Visits**
- **13,000 unduplicated patients**
- **73% Latino, 22% African American**
- **35% Children**
- **500 Seniors**
- **35 New Prenatals Each Month**
- **Uninsured: 35**

What is the issue?

- 1,850 registered children under the age of 5
- High incidence of asthma, obesity, family dynamic issues
- Children unable to succeed in their education – many not be graduating high school/pursuing higher education
- Maternal depression/domestic violence
- Lack of parenting skills
- How do we impact on the health of our community?

Settlement Health-Partnerships

- **Primary Care Development Corporation**
- **East Harlem Community Health Committee**
- **East Harlem Human Services Consortium**
- **New York Academy of Medicine**
- **Mount Sinai Hospital**
- **New York Center for Child Development**
- **NYC DOHMH – PCIP, Harlem Asthma Network, Go Green East Harlem**

Staff Satisfaction

Lickert Scale

Questionnaire-self-report of attitudes toward the project

(4-Strongly agree, 1-Strongly disagree)

- I found this consultation helpful 3.8
- The consultation addressed my needs 3.8
- This project should continue in the community 3.9

Integration of Mental Health at Settlement Health

- Ages and Stages Social-Emotional Questionnaire used to screen children 6 months to 5 years of age.
  - Parents complete the questionnaire in the waiting room at each well child visit
- Psychologist is available 3 days per week to consult with pediatricians and staff
- Referral to Early Intervention, CPSE, and mental health services
- Short term treatment to address behavioral issues (for example-bed wetting, tantrums, eating difficulties, and sleep problems)
- Socialization Groups

What have we done so far?

- Began screening July 2007
- 30% positive rate
- Interventions following positive screens:
  - Referrals and treatment utilizing existing funding streams
    - Early Intervention, Committee on Preschool Special Education
  - Other referrals- Mental health clinics, community resources

Clinical Vignettes Continued

- The pediatrician asked for consultation about a 3 year old child she stated has “sleep and attentional problems.” Upon screening it was revealed that this child had killed two small animals, has difficulty getting to sleep, and has witnessed violence against her mother. This child was evaluated by the CPSE and was engaged in short-term treatment until she was able to be seen through CPSE. The same clinician was able to evaluate, provide short-term treatment, and long-term treatment to this family.

- A 4 year old child already receiving special education services screened positive for social-emotional delays. Family did not want treatment. Approximately 6 months later came to the psychologist asking for help because the child had been asked to leave his daycare. The family has engaged in short-term treatment and the psychologist interfaced with the new daycare in order to advocate for counseling services. The mother has a history of domestic abuse.

Clinical Vignettes

- 3 year old child with language delay. She has lived in a shelter for the past year and she has just moved into her own apartment with her mother. Her mother has a history of domestic violence. This child screened positive for social-emotional delays and was able to obtain additional family counseling services through CPSE.

- Child was born at 24 weeks gestational age the mother was resistant to getting her evaluated for early intervention services. The psychologist was able to explain the process and the need for services while the child was young and the mother agreed to have the child evaluated. The family is currently receiving both physical therapy and family counseling in the home.

- A child whose father was recently deported was having behavioral difficulties. The psychologist was able to see both the child and mother in short-term treatment to aide the mother in helping her child understand her father's absence.

Conclusion

- Model that can be replicated
- Positive impact of current program on families in East and Central Harlem
- Model that needs to be expanded fully