Integration of Mental Health in the Public Health System

The role of the public health system cannot be overlooked during the expected 2009 debate on healthcare. Public health agencies are charged with monitoring and improving the nation's health, with particular emphasis on prevention, early detection and access to treatment for all in need. The issues of wellness, prevention and early intervention must be addressed if we are to ensure that our healthcare system keeps people healthy and remains affordable.

Within public health, there is growing recognition that behavioral health issues need greater attention. Integrating mental health more fully into public health requires greater attention to mental health in traditional public health activities, increased coordination and cooperation among local, state and federal agencies and change in reimbursement policies.

Background

Integration of mental health into the agenda of federal, state and local public health systems is an important step in creating a holistic healthcare system. Public health authorities well appreciate the essential inter-connectedness of mind and body. However, mental health has generally been seen as outside the medical framework, and as a result is too often not included in public health activities.

The public health system has a broad agenda and there are opportunities to incorporate behavioral health in several arenas:

- ♦ Community-wide education
- ♦ Surveillance/epidemiologic surveys
- ♦ Screening
- ♦ Assuring and linking individuals' access to care
- ♦ Identifying underlying causes of disease burden
- ♦ Promoting prevention and early intervention
- ♦ Expanding electronic data systems and information exchange
- ♦ Addressing social determinants of health, such as poverty and violence
- ♦ Disaster response.

Community education/linking individuals to care: Public health has an excellent grasp of communication strategies and a long track record in this area. The public health community's educational role could be expanded, raising awareness about specific mental disorders and providing information on how to access services for those disorders. This community education might focus first on depression, post- traumatic stress and other mental illnesses for which reliable screening tools exist.

JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

1101 15th Street NW, Suite 1212, Washington DC 20005 ◆ 202-467-5730 (v) 202-223-0409 (f) ◆ info@bazelon.org ◆ www.bazelon.org

Subjects for public-awareness campaigns could also include, among other areas, risk and protective factors and children's need for health environments, community and family violence prevention, and workplace mental health promotion.

Surveillance: Public health can play a key role in tracking certain behavioral health issues. In particular, it would be easy and helpful for public health to track suicide attempts and the overall use of the emergency room by people with mental illnesses. This data could lead to assessments of the need to change local policies. Community violence, teen-age pregnancies and other risk factors for social, emotional and behavioral health problems are often measured, but there should be a way to make use of the data to change current practice. Even when such data is collected, there are currently no routine mechanisms for it to be shared with mental health authorities and if it were, there is no certainty that there would be action.

Suicide prevention is an area where public health and public mental health agencies have a mutual interest and ability to intervene.

Screening: Screening targeted to groups at high risk for mental disorders would be most valuable. Screening for maternal depression and other behavioral health problems not only improves the adult's mental health but is a preventive intervention for a group of very high-risk children.[1] Prenatal screening with post-partum follow-up for depression and anxiety could have significant payoffs.[2] In addition, public health agencies could help pediatricians find appropriate behavioral health screening tools for children at risk and refer children who show signs of problems to mental health providers.

Prevention: Suicide prevention is an area where public health and public mental health agencies have a mutual interest and ability to intervene. Youth suicide rates are now rising, increasing by 18 percent from 2003 to 2004, and warrant prompt attention.[3] Public health hot lines for suicide are an important function and improved treatment of depression by mental health providers is a form of suicide prevention. Reducing lead exposure also has significant mental health benefits as even low-level lead exposure can lead to poor executive functioning, attention and learning in early childhood.[4]

Emergency response: Public health swings into action whenever a cluster of events in the community suggests a public health emergency. Unfortunately, mental health emergencies are too often not a part of this role. Unexpectedly high death rates related to substance use or suicide or increases in the numbers of people with mental illnesses who are homeless or who are showing up in hospital emergency rooms rarely result in a public health response. One way for public health to play such a role in "outbreak" investigations might be through the Real Time Disease Detection/Poison Control/Toxic Substance reporting mechanisms that are already in place and funded with preparedness carve-outs.

Other areas: Other areas where public health could play a role include:

- ➢ Initiatives to connect people to services.
- ➢ Encouraging school health clinics to include mental health services can help meet significant unmet need.
- ➢ Working with schools on mental health literacy and helping them engage in practices that strengthen social/emotional development and programs to foster a positive school climate (such as positive behavioral support initiatives promoted by the Department of Education) can significantly enhance school success for at-risk youngsters.

> ➢ Promotion of electronic health information that includes both health and mental health data, with appropriate privacy protections.

> ➢ Improving disaster response by bringing mental health expertise in early can have significant pay-off (the Katrina experience is relevant here).

Focusing on very young children: In addition to incorporating mental health issues into their ongoing activities, public health entities should focus on one of the most promising areas of mental health prevention and intervention: improving the social and emotional development of very young children and identifying early any mental health problems in infants and toddlers. Approximately 20 percent of children will develop a mental health disorder that leads to functional impairments. Mental disorders are being identified in younger and younger children as our understanding improves.[5]

Recent breakthroughs in neuroscience have shown how easily the developing brain can be affected by adverse environmental factors and how possible it is to rewire the neurons and change a child's trajectory in terms of mental health and resulting behavior issues.

Recent breakthroughs in neuroscience have shown how easily the developing brain can be affected by adverse environmental factors and how possible it is to rewire the neurons and change a child's trajectory in terms of mental health and resulting behavior issues.[6] Risk factors for childhood mental disorders that are amenable to intervention are relatively well understood. They include exposure to toxic social and physical environments such as pre- and post-natal exposure to harmful substances like lead and illicit drugs, poverty, maltreatment, neglect, parental psychopathology and exposure to family and community violence.[7] Fortunately, the effects of these deleterious social and environmental risk factors can be lessened and often reversed with appropriate interventions.

Tackling a specific, targeted public health initiative for prevention and early intervention of mental health problems in very young children would be a more efficient and effective policy compared to some current disjointed approaches across a number of different areas and throughout the lifespan. Public health agencies at the federal, state and local levels should be involved. Components of such an initiative should include:

> ➢ Pre-natal and peri-natal screening for maternal depression.[8]

> ➢ Pre-natal education and screening on substance abuse issues and the potential for fetal alcohol syndrome, with a particular focus on any mother who has previously given birth to an infant with FAS.[9] [10] [11]

> ➢ Home visiting by public health nurses (early and frequent) to both screen and provide robust caretaker education and coaching on appropriate parenting.

> ➢ Anticipatory guidance by pediatricians, particularly for high-risk mothers.

> ➢ Coordination with other agencies providing relevant services.

> ➢ Encouraging and supporting (through education and mental health consultation) Head Start and other child care programs to address behavioral health problems appropriately and to avoid expelling youngsters from the program.

> ➢ Screening in Early Start and Head Start programs to identify youngsters exposed to violence, with follow-up treatment when necessary, along with reporting to public health agencies.

> ➢ Collection of surveillance data on these specific populations and sharing of this data with providers, especially pediatricians, so they will focus more on these problems.

There is significant evidence in support of these interventions. For example, home-visiting programs have demonstrated positive results in mitigating the effects of maternal depression and child maltreatment, by effectively improving the mother-infant relationships and infant scores on cognitive tests and measures of social functioning.[1]

Linkage between public health providers and mental health providers would be needed to create seamless follow up for adults and children identified as requiring mental health treatment. Child welfare agencies might be interested in collaborating with public health and public mental health agencies on these activities and potentially contributing resources to such an initiative. Abused and neglected infants demonstrate a number of disturbing symptoms such as post-traumatic stress, cognitive dysfunction, greater aggressiveness and more fear in response to angry interactions between adults.[13]

Public health agencies should work to incorporate mental health issues into their agenda (in partnership, as appropriate, with public mental health agencies).

Federal policy changes: A national program along these lines could be fostered by the federal government. Medicaid reimbursement could be made available for programs that meet certain standards and provide this full range of interventions. While such an initiative can be launched without specific federal funds, a demonstration (potentially funded through the Maternal and Child Health program and with appropriate evaluation to determine quality of care and cost-benefits) could jump-start the program.

Changes to Medicaid policy could also foster improved behavioral health screening and prevention as well as funding other services. There is potential for such a program to have a side benefit in reducing costs caused by the high staff turnover in Early Start and Head Start programs that is due in part to frustration with behavioral health problems of the children.

Centers for Disease Control: The CDC should expand its behavioral health initiatives. Currently, there is a program to raise the level of recognition and treatment of attention deficit disorder. CDC also engages in limited data collection on mental health issues (including measures of depression and serious psychiatric disorders and the Youth Risk Behavior survey) and work by the chronic disease center. The division of adolescent and school health in CDC also addresses behavioral health issues to some extent.

Recommendations

> Public health should undertake a nationwide initiative of prevention and early intervention for very young children from birth to three or five years of age.

> Public health agencies should work to incorporate mental health issues into their agenda (in partnership, as appropriate, with public mental health agencies).

> CDC should collect more information on the need for and the utilization and quality of mental health care and consider new initiatives around very young children's mental health issues and/or violence prevention.

> The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) rules should be amended to incorporate more specific requirements on screening for mental health issues of children of all ages and for substance abuse problems in older children and parents.

> ➢ Medicaid should reimburse providers for services to caregivers of very young children when the purpose of the services is to improve the mental health of a child age zero to five. This should include services that improve the parent-child bond and the social/emotional development of the infant/toddler.

Expanding availability of mental health services within the public health context must be placed high on the reform agenda.

Expanding availability of mental health services within the public health context must be placed high on the reform agenda. Leaders in public health have developed proposals that are generally very compatible with the recommendations above.[14] However, none of these reforms can be effectively implemented without undermining other important ongoing public health work unless there is a significant increase in the country's investment in public health.

> ➢ As part of health reform, an investment of $10 per person per year should be made to expand proven public health programs, including programs to improve the nation's mental health.

1   Depressed parents and family functioning: Interpersonal effects and children's functioning and development. In T. Joiner & J.C. Coyne (Eds.). The interactional nature of depression (p 299-327). Washington, DC: American Psychological Association; Garstein, M.A. & Bateman, A.E. (2008). Early manifestations of childhood depression: Influences of infant temperament and parental depressive symptoms. *Infant and Child Development, 17, 223-248.*; Davis, E.P., Glynn, L.M, Schetter, C.D., Hobel, C., Chicz-Demet, A.C., Sandman, C.A. (2007). Prenatal exposure to maternal depression and cortisol influences infant temperament. *Journal of the American Acadamy of Child and Adolescent Psychiatry, 46, 737-746.*

2   Marchand, J. & Hock, E. (1998). The relation of problem behaviors in preschool children to depressive symptoms in mothers and fathers. *Journal of Genetic Psychology*, 159, 353-366.

3   **Bridge, J.A, Greenhouse, J.N., Weldon, A.H., Campo, J.V. & Kelleher, K.J., Suicide Trends Among Youths Aged 10 to 19 Years in the United States, 1996-2005**. *JAMA.* 2008;300(9):1025-1026.

4   Canfield, et al. (2006); *Child Neuropsychology, 9, 35-53.* Canfield, R.L., Gendel, M.H., Cory-Slechta, D.A. (2004). Impaired neuropsychological functioning in lead-exposed children. *Developmental Neuropsychology, 26, 523-540.*

5   Department of Health and Human Services (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services.

6   National Research Council and Institute of Medicine, (2000). *From Neurons to Neighborhoods: the Science of Early Childhood Development.* Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips, eds. Board on Children, Youth and Families, Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

7   For example, preschoolers exposed to sociocultural and biological risk factors demonstrate significantly higher degrees of internalizing behaviors and other behavioral problems than their unexposed peers (Adams, C.D., Hillman, N., Gaydos, G.R. (1994). Behavioral difficulties in toddlers: Impact of sociocultural and biological risk factors. *Journal of Clinical Child Psychology, 23, 373-381.*Gilman, S.E., Kawachi, I., Fitzmaurice, G.M., Buka, S.L. (2002). Socioeconomic status in childhood and the lifetime risk of major depression. *International Journal of Epidemiology, 31, 359-367;* Harpaz-Rotem, I., Murphy, R. A., Berkowitz, S., Marans, S., & Rosenheck, R. A. (2007). Clinical epidemiology of urban violence: Responding to children exposed to violence in ten communities. *Journal of Interpersonal Violence, 22*(11), 1479-1490.; Saltzman, K.M., Holden, G.W., & Holahan, C.J (2005). The psychobiology of children exposed to marital violence. *Journal of Clinical Child and Adolescent Psychology, 34*, 129-139.; Cummings, E.M. & Davies, P.T. (1999). Depressed parents and family functioning: Interpersonal effects and children's functioning and development. In T. Joiner & J.C. Coyne (Eds.), The interactional nature of depression (p 299-327). Washington, DC: American Psychological Association.)

8   Maternal depression is thought to disrupt the development of mother-infant attachment and to disrupt the quality of mother-child interactions, which may lead to an increased risk for a variety of social, emotional

and behavioral problems, as well as poor cognitive development (Cummings, E.M. & Davies, P.T. (1999). Depressed parents and family functioning: Interpersonal effects and children's functioning and development. In T. Joiner & J.C. Coyne (Eds.), The interactional nature of depression (p 299-327). Washington, DC: American Psychological Association; Marchand, J. & Hock, E. (1998). The relation of problem behaviors in preschool children to depressive symptoms in mothers and fathers. *Journal of Genetic Psychology*, 159, 353-366; Rubin, K. H., Both, L., Zahn-Waxler, C., Cummings, E. M., & Wilkinson (1991). Dyadic play behavior of children of well and depressed mothers. *Development and Psychopathology, 3*, 243–251.

9   Substance use during pregnancy and exposure to lead in early childhood can have devastating effects on infant and childhood development, including impaired neurobehavioral development, poor performance on intelligence tests, and increased risk of developing behavioral disorders, learning disabilities and other mental health problems (Canfield, R. L., Kreher, D.A., Cornwell, C., Henderson, C.R. (2003). Low-level lead exposure, executive functioning, and learning in early childhood. *Child Neuropsychology, 9,* 35-53.)

10 Exposure to cocaine confers a nearly three-fold risk of developing learning or intellectual disabilities and decreased IQ scores. (Morrow,C.E., Culbertson, J.L., Accornero, V.H., Xue, L., Anthony, J.C., Bandstra, E.S. (2006). Learning disabilities and intellectual functioning in school-aged children with prenatal cocaine exposure. *Developmental Neuropsychology, 30,* 905-931.)

11 Smoking and use of alcohol or illicit drugs have been shown to affect infant and toddler development (Sood, B., Delaney-Black, V., Covington, C., Nordstrom-Klee, B., Ager, J., Templin, T., et al. (2001). Prenatal alcohol exposure and childhood behavior at age 6 to 7 years: A dose-response effect. *Pediatrics*, 108, e34.; Wakschlag, L.S., Leventhal, B.L., Pine, D.S., Pickett, K.E., Carter, A.S. (2006). Elucidating early mechanisms of developmental psychopathology: The case of prenatal smoking and disruptive behavior. *Child Development, 77,* 893-906.)

12 Cicchetti, D. & Toth, S. (2004). Child maltreatment. *Annual Review of Clinical Psychology, 1, 409-438;* Cummings, E.M. & Davies, P.T. (1999). Depressed parents and family functioning: Interpersonal effects and children's functioning and development. In T. Joiner & J.C. Coyne (Eds.), The interactional nature of depression (p 299-327). Washington, DC: American Psychological Association.

13 Saltzman, K.M., Holden, G.W., & Holahan, C.J (2005). The psychobiology of children exposed to marital violence. *Journal of Clinical Child and Adolescent Psychology, 34,* 129-139; Cicchetti, D. & Toth, S. (2004). Child maltreatment. *Annual Review of Clinical Psychology, 1, 409-438*

14 Recommendations for improving the Public Health System are contained in the *Blueprint for a Healthier America*, developed through a consensus-building process by the Trust for America's Health.