ISSUE BRIEF REFRAMING MENTAL HEALTH PRACTICE FOR CHILDREN, YOUTH, AND FAMILIES: In Search of Developmental Competencies to Improve Functioning Across Life Domains

OUTCOMES ROUNDTABLE FOR CHILDREN AND FAMILIES

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The Outcomes Roundtable for Children and Families (ORCF)—a consortium of researchers, youth, family members, providers, and policymakers—undertook an exercise to identify key factors impacting children's mental health in the era of recently passed legislation, including the Mental Health Parity and Addiction Equity Act of 2008 and the Patient Protection and Affordable Care Act (PPACA). As mental health parity and healthcare reform is implemented, the ORCF has identified a series of indicators that could be tracked to ensure children's mental health needs are being promoted that are consistent with the mission and vision of the Substance Abuse and Mental Health Services Administration (SAMHSA). The first step in this work was to identify key, core lifetime outcomes that all families want for their children. These core outcomes are that children are "at home, in school and out of trouble"—outcomes that are no different for parents whose children experience mental illness.

Current approaches to understanding child and adolescent mental health needs focus on an inventory of symptoms that lead to diagnoses that provide the focus for interventions. Although there have been attempts in recent years to ensure that strengths are included in the diagnostic formulation, all too often strengths are an afterthought and are not the focus of our clinical understanding of the child. The ORCF endeavored to turn this paradigm on its head, because we believe that current diagnostic instruments have a pathology and deficit focus. It is our premise that the acquisition of developmental competencies are necessary to achieve the lifetime outcomes we articulate in this issue brief. In fact, we hypothesize that most evidence-based practices (e.g., Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, and Multisystemic Therapy) serve exactly this function of skills acquisition, in support of enhancing developmental competencies that lead directly to positive lifetime outcomes. If our hypothesis is correct, then future funding decisions should be based upon whether the funded service or intervention can be shown to support one or more of the developmental competencies identified in this issue brief.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: IMPACT ON CHILDREN'S MENTAL HEALTH SERVICES

The PPACA provides opportunities for defining and reframing outcomes and for service reimbursement for children's mental health services. New service reimbursement opportunities include: (1) the addition of mandated mental health, substance abuse, and prevention benefits as standard benefits (Farrell, Hess, & Justice, 2011); (2) a prohibition from excluding preexisting conditions, which include mental health conditions; and (3) the extension of benefits to dependent young adults until age 26 (Substance Abuse and Mental Health Services Administration, 2010). States and health plans also can add benefits to their individual plans. These changes in covered services will increase access to overall mental health and addictions services and expand public and private insurance coverage for mental health and addiction treatment, including an expansion of Medicaid and the Children's Health Insurance Program (CHIP). The expansion of Medicaid to 133 percent of the poverty line and increased CHIP coverage to about 6.5 million additional children is estimated to increase enrollment in the programs by 33 percent by 2019.

Another important PPACA requirement relevant to children's mental health services is a new requirement for patient reported outcomes (PRO) as a valid measure of the health service effectiveness. PROs are recovery-oriented and person-centered interventions aimed at prevention, treatment or service care, and rehabilitation of mental and addictive disorders. PROs provide an opportunity to improve healthcare outcomes by giving decision makers (families and

youth) the power to determine how their healthcare affects what they are able to do and how they feel. This shift, from the use of predetermined measures selected by the healthcare provider using standardized instruments to PROs, provides families and youth the opportunity to determine their own behavioral health services outcomes (Farrell, Hess, & Justice, 2011).

POSITIVE MENTAL HEALTH OUTCOMES —A PUBLIC HEALTH APPROACH

Public health is "what society does collectively to assure the conditions for people to be healthy" (Committee for the Study of the Future of Public Health, 1988). Fostering the social and emotional health of children is a key factor in overall healthy child development and must be treated as a national priority (Committee for the Study of the Future of Public Health, 1988; Corliss, Shankle, & Moyer, 2007; U.S. Public Health Service, 2001). Ignoring the impact mental health has on healthy child development could have a deleterious threefold effect: interference with prevention and intervention efforts; reduced access to care; and prevention of the prioritization of children's mental health needs as a critical national issue (Society for Research in Child Development, 2009; U.S. Public Health Service, 2001). Without prevention and intervention efforts, childhood mental health challenges may persist through adulthood and intensify, which may lead to school failure, poor employment opportunities, poverty, or adverse long-term health and mental health outcomes (Felitti et al., 1998; Substance Abuse and Mental Health Services Administration, 2007). Prevention efforts should focus on the promotion of positive mental health attitudes and behaviors for children such as the following, identified by The Mental Health Foundation (1999):

Positive Mental Health Attitudes and Behaviors

- Develop psychologically, emotionally, creatively, intellectually, and spiritually
- Initiate, develop, and sustain mutually satisfying personal relationships
- Face problems, resolve them, and learn from them
- Be confident and assertive
- Be aware of others and empathize with them
- Use and enjoy solitude
- Play and learn

Two other key issues in the healthy development of a child's social and emotional life are resiliency and protective factors. Resiliency is the process by which individuals display positive adaptive characteristics to combat significant adversity or trauma (Luthar & Cicchetti, 2000). Two critical components that compromise resiliency are adversity and positive adaption. Key resiliency behaviors identified by Apfel and Simon (1960), include the following:

Resiliency Characteristics

- Curiosity and intellectual mastery
- Compassion, with detachment
- Ability to conceptualize
- Conviction of one's right to survive
- Ability to remember and invoke images of good and sustaining figures
- Ability to attract and use support
- A vision of the possibility and desirability of restoration of a civilized moral order
- The need and ability to help others
- An affective repertory
- Resourcefulness
- Altruism toward others

Prevention programs focused on enhancing strengths and resilience of children and families have been found to be effective. Protective factors, which mitigate adverse life circumstances in a positive capacity and can be enhanced and supported in prevention and intervention services, include the following (The Mental Health Foundation, 1999; Wells, Barlow, & Stewart-Brown, 2001):

Protective Factors

- Individual emotional resilience
- Confidence in one's own sense of personal value
- Supportive relationships within the family and in the wider community
- Social inclusion
- A healthy social and economic environment

This brief focuses attention on the protective factors and defines the developmental competencies essential for achieving lifetime outcomes parents want for their children.

WHAT ARE THE FUNCTIONAL LIFETIME OUTCOMES PARENTS WANT FOR THEIR CHILDREN WITH MENTAL ILLNESSES?

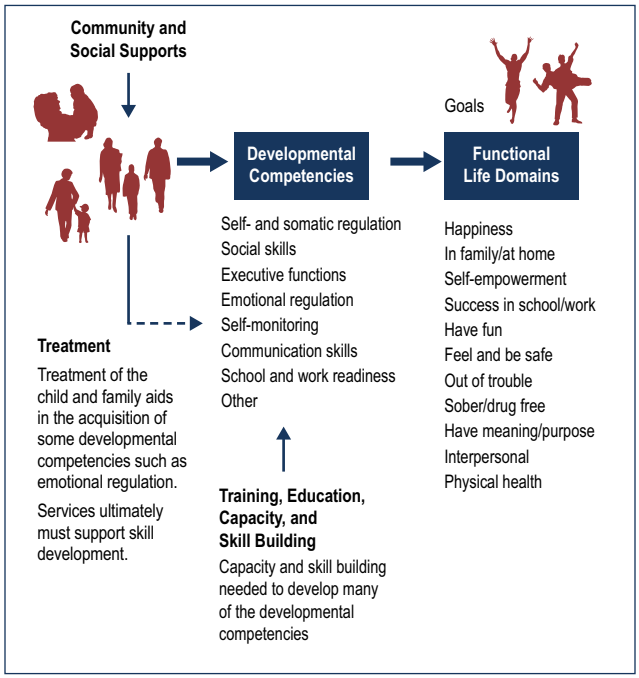
The ORCF initially developed a list of lifetime outcomes we believed all parents desired for their children. We then conducted an informal survey of parents and advocates* and developed a list of their top eleven outcomes. This list is not meant to be all inclusive or to suggest that all children will experience success in all areas. One parent's response to our question was that lifetime outcomes are ultimately defined by each individual child or parent. An example of this is that success in school may be defined as a child is attending school regularly and showing academic gains commensurate with his or her abilities instead of being on the honor roll. Ultimately, parents want their children to be accepted for themselves.

We believe that all parents want some version of the following for their children:

1. To be happy; the internal experience of being free from anxiety or depression
2. To live at home, with their family and in their community
3. The capacity for self-empowerment, self-control, self-acceptance, self-awareness, self-efficacy, self-advocacy, and self-esteem and ultimately to feel in control of one's life
4. Success in school or work
5. To have fun and be able to engage in and enjoy community activities, including sports and play
6. To feel and be safe
7. To stay out of trouble
8. To be sober and/or not abusing substances
9. To have meaning and purpose in their lives (spirituality, altruism)
10. To develop healthy and positive interpersonal skills that support meaningful relationships, sexuality, fitting in, having friends, and a natural support system
11. To experience positive physical health and to receive the healthcare needed to treat physical illness

Some parents also identified the need to prepare youth for independence as an adult, including access to a postsecondary education, affordable housing, and an available means of transportation.

*[Lead Family Contacts and family members of children and youth with mental health challenges who are members of the Family Involvement Community of Practice listserve of the Technical Assistance Partnership (TA Partnership) were surveyed. The TA Partnership provides technical assistance to the SAMHSA-funded systems of care grantees.]



REFRAMING MENTAL HEALTH PRACTICE FROM A SYMPTOM REDUCTION, DEFICIT MODEL, TO THE PROMOTION OF DEVELOPMENTAL COMPETENCIES, A SKILLS-BUILDING AND STRENGTHS-BASED MODEL

Traditionally, mental health outcomes focus on the presence or absence of pathology. Most children's mental health assessment instruments are designed

to identify how youth fail to achieve normative development and then provide a series of psychiatric diagnoses. The ORCF is seeking to identify which developmental competencies are needed to foster the positive lifetime indicators described previously. This process focuses attention on critical developmental areas that should be targets for supports and services, including clinical interventions.

Developmental Competencies Necessary to Support Positive Lifetime Mental Health Outcomes

a. Social Skills: Learning how to get along with peers as well as caregivers and other adults

b. Executive Functioning: Ability to direct attention, learning, and problem solving

c. Emotional Regulation: Cognitive control of emotional arousal

d. Self-Monitoring: The acquisition of the capacity for self-observation and self-evaluation

e. Self-Reflection: Evaluating one's own behavior in relation to internal standards of self

f. Reality Testing: Ability to take the "de-centered" viewpoint of a neutral observer

g. Behavioral Self-Control: Using internal self-reward and self-perception to plan actions over a longer course of time

h. Communication Skills: Expressive and receptive oral language, as well as written language abilities

i. Attachment: Basis for emotional and social development

j. Self-Efficacy: Realistic self-esteem

k. Goal Direction: Ability to choose courses of action that maximize reinforcement and self-esteem

l. Stress Tolerance and Management Strategies: Successful coping with stressors

m. Anxiety Management: Ability to reduce anxiety and to isolate and control its effects

n. Positive Future Orientation: Integrating self across time, incorporating memories and present time while projecting into the future

o. School and Work Readiness Skills: The concrete positive future orientation

p. Ability to Engage in Positive Leisure Activities: Positive sense of self, supported by reciprocal and rewarding relationships with adults and peers

q. Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs): Being able to care for the most fundamental basic sustenance and hygiene needs (ADLs) as well as for independent adult life (IADLs)

r. Time Management: Ability to use time functionally

s. Ability to Develop Supportive Resources: Understand and accept the support of others in life tasks

t. Adaptation to Change: Assess changes in the environment and significant others; acquire new skills and accommodate new circumstances

u. Internal Self-Regulation of Body Rhythms: Monitor and adjust regulatory cycles to keep them optimally serving development

v. Management of Response to Physical Illness or Somatic Complaints: Maintain a fundamental sense of self through challenges, while adaptively tailoring perceptions and activities to the demands of illness

RELATION OF DEVELOPMENTAL COMPETENCIES TO EVIDENCED-BASED PRACTICES

Children's mental health disorders interrupt and/or reflect delays in acquisition of developmental competencies (e.g., regulatory functions and impulsivity, executive functions used in problem solving, social skills needed in relational development). Interruptions can accumulate

to produce well-known functional impairments, which should more appropriately be seen as delays in acquisition of developmental competencies rather than as "weaknesses" or pathology. Addressing these interruptions and delays is critical to the return to normal development, which is the major underpinning of resilience.

The recent proliferation of intervention research, or evidence-based practices, is targeted at both externalizing and internalizing disorders. Interventions measure effects in terms of both specific symptom reduction and enhanced functional development. Various meta-analyses (Chorpita & Daleiden, 2010) help to distinguish the common elements that occur across families of related interventions (e.g., cognitive behavioral therapies, caregiver-administered behavioral interventions, interpersonal therapies). At the heart of most therapies is the teaching of and support for skills acquisition necessary to return to normal development. Examples of skill development include the following:

Examples of Skill Development

- Mood and affect monitoring and regulation, related to competencies in self-knowledge and self-management
- Development of aspects of attention and organization, related to competencies in executive functioning
- Problem solving, related to competencies in both self-management and social relationships
- Social skills, related to competencies in relational development and self-perception
- Activity scheduling, related to competencies in regulatory functioning and self-knowledge

Interventions that enhance skills underlying developmental competencies help build "virtuous cycles" (Masten & Coatsworth, 1998). Enhanced skills promote greater competency, boosting a developing sense of self, which serves as the basis for confidence in continued success and expanded spheres of application, producing characteristic hallmarks of resilience.

IMPLICATIONS FOR POLICY AND PRACTICE

A public health prevention and resiliency focus in the provision of children's mental health services and supports is in keeping with major national policy directions, as well as evidence-based practice. There are important implications for immediate next steps in the realms of practice, policy and funding priorities, training, and research.

Practice

The most significant practice impact of focusing on developmental competencies is in early childhood systems, with increasing implementation of models that support skill development. Evidenced-based practices that focus on helping parents learn how to help their children develop these competencies will help prevent later deficits in day-to-day functioning.

Practice change emerging from a focus on developmental competencies need not be limited to early childhood. These competencies can be developed throughout childhood, adolescence, and young adulthood. Identifying common elements, interventions, and evidence-based practices that help a young person develop lagging or lacking skills will yield improved outcomes. Approaches that are strengths based and strengths building are proving to be the most effective in working with children and adolescents. This shift from the historical focus on pathology does not imply turning a blind eye to the very real deficits and problems the child presents, nor does the shift connote a focus on superficial or artificial strengths. It does, however, imply a reshaping of practice to interventions designed to create the conditions in the family and community under which the child can move forward developmentally and acquire the competencies for a successful life.

Policy and Funding Priorities

To date, policy and funding have been focused on remediation of deficits. This is beginning to change in many states. Institutionalizing policy expectations that services and supports focus on strengths-based approaches that promote healthy families and skill development for children will lead to changes in

funding priorities and practice. It is important that policymakers discriminate in their requirement for evidence-based practices, incentivizing those programs and practices that are competency oriented and prioritizing approaches that can be individualized to the unique characteristics of each child and family. The ACA, with its national focus on prevention and innovation, and developments at the Center for Medicare and Medicaid Services focusing on innovative demonstration projects, establish a national framework for states and local communities to draw from in the evolution of their systems of services and supports. Policy and contract mechanisms that focus on patient-centered outcomes also will help shape the evolution of the system in this direction.

Training

Reshaping children's mental health practice will require extensive workforce development. This ideally will begin in the institutions of higher learning with revision of their core curricula across disciplines. The emerging body of research and literature affords an opportunity for this significant undertaking in institutions of higher learning.

Similar efforts in the existing workforce are critical. A push for evidence-supported work and outcomes in policy will need to be accompanied by resources for technical assistance and training. Most critical will be efforts that help practitioners recognize and acknowledge the effective power of interventions that build developmental skills.

Research

Research in this arena is becoming increasingly robust. Nonetheless, it is critical to continue to focus research efforts on promoting mental wellness, including implementing measurement systems that assess functional outcomes by measuring the presence of competency, not merely the absence of deficits. This research also will help reshape practice, policy, and training.

Promoting mental wellness and treating mental illness are complementary approaches to the development of resilience in children and youth affected by these illnesses (Miles, Espiritu, Horen, Sebian, & Waetzig, 2010). The nature of developmental competencies at the nexus of these approaches creates a framework for understanding why emerging research and outcome data indicate that targeting skill acquisition interventions is more effective and longer lasting than traditional symptom focus interventions. This is a unique time when research, practice, policy, and funding initiatives are changing, creating the opportunity for fundamental rethinking and reshaping. The urgency for real change is high, and the children and families of our country deserve no less.

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