

Training and Family Support for Children with Behavioral Issues

About the Title V Block Grant

The federal Title V Maternal and Child Health (MCH) Block Grant helps states ensure the health of all mother and children. As part of Minnesota's Title V Block Grant activity requirements, the MDH conducts a statewide needs assessment every five years. The needs assessment provides guidance to Title V activities for the next five years by identifying priority issues. This fact sheet describes one of Minnesota's priority issues.

Seriousness of the Issue

"Children with special health needs" by definition, includes children whose conditions are mental or behavioral in nature. In addition, children with chronic physical conditions, physical disabilities and developmental disabilities are at increased risk for developing mental health disorders.¹

Nationwide 21.1% (Minnesota 23.3%) of CSHCN have depression, anxiety, eating disorder or other emotional problems. In Minnesota that is over 40,000 children.²

Only 51.8% of CSHN in Minnesota receive coordinated ongoing comprehensive care within a medical home.³ In Minnesota, 58.3 families of CSHN said that they always get the specific information they need from doctors and other health care providers while 14.1% say they never get this needed information.³

Over 40,000 (29%) of the children with special health needs in Minnesota need mental health care. An estimated 6,720 children with special health needs did not receive all needed mental health care.⁴

People in rural or remote areas have inadequate access to care, limited availability of skilled care providers, lower family incomes, and greater social stigma for seeking mental health treatment than their urban counterparts.¹

Nearly 60% of adolescents referred by their primary care provider for mental health services never receive them.⁵ Lack of mental health professionals contributes to this gap in services. Only 5% of small rural counties have a child psychiatrist; only 25 percent have a general psychiatrist.⁵

Issues related to stigma can also be a contributing factor in families not receiving the support they need.

- Fifty percent believe mental health treatment will make their child an "outsider" at their school;
- More than 50 percent believe that people in the community know the children being treated regardless of confidentiality laws;
- Eighty-five percent believe doctors are overmedicating children with common behavior problems;
- Nearly 70 percent believe medications will have long-term negative effects on a child's development; and
- More than 50 percent believe that medications for behavioral problems prevent families from working out problems themselves.⁵

Untreated behavioral disorders affect not only the child but also the siblings, parents and caregivers. The impact on parents includes impeded work performance, additional stress and increased chemical abuse. Increases juvenile crime on the part of children with behavior disorders impacts an entire community.⁴

On average, child and adolescent behavioral health disorders cost \$937 annually for outpatient care and \$5,384 for inpatient care.⁵

Racial and ethnic minority populations are less likely to have access to available mental health services, less likely to receive needed mental health care and often receive poor quality care according to National findings.⁵

Caregiver burden refers to the "impact that living with a patient (i.e. child) has on family's daily routine and health." Nearly 40% of parents caring for a child diagnosed with an emotional or behavioral impairment report this burden.⁵



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Children with emotional or behavioral issues were 20 times more likely to be asked to leave childcare than children without these issues.

Youth with behavioral health disorders incur more missed school days and experience reduced potential for education, employment, and income. Indirect costs to the employer include absenteeism and reduced productivity of the caregiver parents.⁵

Gaps exist for families of children with moderate mental health conditions and for those who do not meet financial eligibility criteria for training and support programs. During times of budget shortfalls waiting lists for services grow, fees for families increase, and types of services (e.g. personal care attendant) come under scrutiny.⁶

While parents state their desire for more information about the child's chronic condition(s) and its implications consistently and independent of the severity of diagnostic categories, pediatricians regularly underestimate this desire and often are not aware of the parents need for training and support.⁷ Assessing family status as it relates to parental health, emotional support, financial ability to meet basic needs and relationships that affect parenting is often lacking.⁸

Evidence-Based Strategies

Unlike adults, nearly 80 percent of children receive treatment for emotional or behavioral problems in the school system. School-based interventions such as targeted classroom-based management and behavioral consultation have proven effective in reducing aggressive and disruptive behaviors.⁵

Schools are the optimal setting in which to identify at-risk children and promote prevention and intervention programs. School Mental Health programs also enhance opportunities for collaboration between parents, teachers and mental health professionals.⁵

Strong evidence supports the use of “collaborative care” for behavioral health disorders in primary care practice settings. Collaborative care interventions have two key elements. The first is case management and the second engages a consulting psychiatrist. For effective collaborative care, providers must invest significant time on non-face-to-face aspects of treatment. However, the lack of time and reimbursement limits implementation. As a result, parents may spend a significant amount of time coordinating care.⁵

Work-life balance is the main contributor to caregiver burden. Resources made available at the worksite can help decrease caregiver strain, healthcare utilization and workforce reductions, while helping parents and caregivers maintain the financial resources necessary to care for their family.⁵

Parenting programs that offer on-site child care while parents are in session or assist with transportation needs have greater success in keeping parents in treatment. Interventions may need to be delivered within the communities in which families reside, and must be offered at convenient times and locations.⁹

Practitioners employing parent training must be able to successfully combine the directive, “teaching” skills intrinsic to behavioral parent training with relationship building skills, such as empathy, warmth, and humor.⁹

Prosocial Family Therapy, developed by Blechman and colleagues, specifies a close working relationship and treatment involvement among all adults who service caretaking roles in the target child's life (e.g. at school, in the juvenile justice system)⁹

Behavioral parent training is a treatment with substantial data to support its effectiveness that is available to families who request or require assistance in managing difficult child behavior or strengthening parenting efficacy.⁹

Wraparound has been identified variously as an evidence-based practice and as a “promising” or “emerging” best practice. Wraparound process should increase the “natural support” available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships.¹⁰

Support, Empowerment, and Education (SEE) group interventions reported high levels of satisfaction with the sessions. Parents report improved parenting skill and their children improved in their behavioral functioning at home and school environments.¹¹

Current Resources and Capacity

Providing individualized, coordinated care requires working across organization and agency boundaries. This creates an extremely complex implementation context and one that is likely to vary substantially from one community to the next.¹⁰

Wraparound will not be successful over the long run unless it is embedded in an organizational and system context that is transformed or transforming. Strength-based, family-driven, and culturally competent practice at the team level can only flourish when the lead agency – and to some extent the partner agencies as well – puts these values into practice at the organization level.¹⁰

There is a clear need to develop organizational-level strategies to build community capacity to provide inclusion of informal and community supports in the plan and for system-level policies that encourage these activities and provide necessary funding.¹⁰

There is statewide awareness about the impact of children and youth with behavioral issues have on communities in terms of educational resources, the need for inpatient hospital beds and psychiatric care, substance abuse treatment and involvement of law enforcement.

The Minnesota Department of Health, Education and Human Services all are addressing the issue of children's mental health. DC: 0-3 Diagnostic trainings have been co-sponsored throughout the state. Advocacy groups such as Minnesota Association of Children's Mental Health, The National Alliance on Mental Illness and PACER also provide trainings for families related to children's mental health issues.

The Minnesota Thrive Initiative engages a diverse cross-section of community members to create networks of local services and resources that help to ensure young children are ready for kindergarten and school success. The networks provide technical assistance, training and financial resources to design and implement a local system that supports the healthy social and emotional development of young children.

MCSHN District Staff live in the communities for which they provide technical assistance and consultation and are in unique positions to assist in building the local capacity of systems that serve children with behavioral issues and their families. MN legislation to establish health care homes will increase the support families receive through care coordination and systematic quality improvement.

¹ Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-2006.

² CSHCN data: Condition-specific profile nationwide (2005-2006). Retrieved from World Wide Web on August 19, 2009:

www.cshcndata.org/Content/Default.aspx.

³ Slaits Data Minnesota, (2005-2006). Retrieved from the World Wide Web on August 16, 2009:

www.cdc.gov/nchs/slaits/cshcn.htm.

⁴ Children with special health needs families receive needed services. (2004). *Fact Sheet. Minnesota Department of Health*. 1-4.

⁵ Krackowsky, K., Reagin, A. & Sherrets, D., (2009). An Employer's Guide to Child and Adolescent Mental Health. *National Business Group on Health*. 1-39.

⁶ Children with special health needs families receive needed services. (2004). *Fact Sheet. Minnesota Department of Health*. 1-4.

⁷ Children with special health needs condition specific health information. (2004). *Fact Sheet. Minnesota Department of Health*. 1-3.

⁸ Children with special health needs knowledge of child development. (2004). *Fact Sheet. Minnesota Department of Health*. 1-3.

⁹ Forehand, R. & Kotchick, B., (2002). Behavioral parent training: current challenges and potential solutions. *Journal of Child and Family Studies*, 11, 377-384.

¹⁰ Koroloff, Nancy, & Walker, Janet. (2007). Grounded theory and backward mapping: exploring the implementation context for wraparound. *Journal of Behavioral Health Services and Research*. 443-458.

¹¹ Evans, Mary, Kuhn, Mary, & Ruffolo Mary. (2006). Developing a parent-professional team leadership model in group work: work with families with children experiencing behavioral and emotional problems. *Social Work*, 51, 39-47.