Reducing Mental Health Inequalities in Adolescents and Young People

18th International Conference on Health Promoting Hospitals and Health Services

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Viktor E. Kacic

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und Psychotherapie
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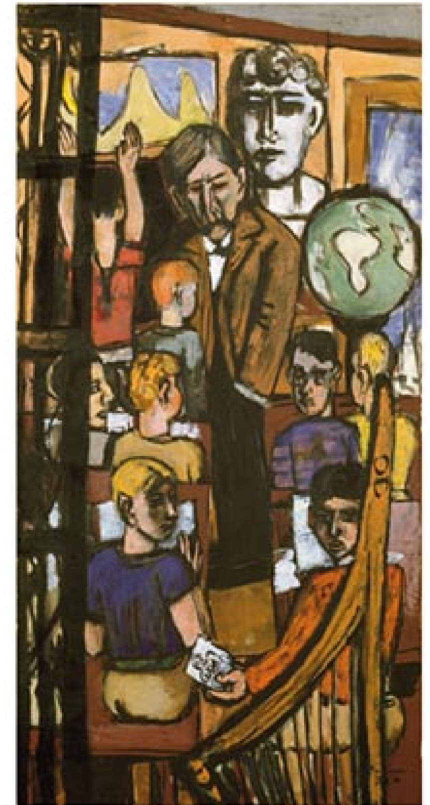
Jugendalters



Max Beckmann, Beginning, 1946-49, Öl auf Leinwand, Mittelteil 175 x 150 cm, Flügel je 165 x 85 cm, The Metropolitan Museum of Art, New York,
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Individual Risk Factors

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- Genetic influence
- Substance abuse during pregnancy
- Birth complications
- Low birth weight
- Chronic somatic disorders
- Difficulties in emotion regulation
- Difficult temperament
- Exposition to agression, violence, trauma
- Neglection
- Low school achievement
- Social incompetence

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kjppköln
www.uni-koeln.de/med-fak/kjp

M. Döpfner 2006

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Parental and Social Risk Factors

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- Mental disorder of parents
- Low education level of parents
- Dysfunctional parenting
- Partner conflicts/divorce
- Disorganised families
- Poverty, low socioeconomic status
- Discrimination
- Migration
- Isolation
- Dissocial peer groups

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Individual Protective Factors

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- Female gender
- High intellectual capacities
- Self confidence
- Positive self concept
- Positive temperament factors
- Problem solving abilities
- Social skills
- Stress management strategies
- Coping strategies
- Positive attachment

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Parental and Social Protective Factors

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- Parental warmth
- Cohesion and adaptive skills of the familiy
- Guidance of the child
- Positive parent - child interaction
- Social help/assistance of familiy and friends
- Income fairness
- High educative possibilities
- Social network
- Integration of minorities

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Possible Operationalisation

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- Chronic dysharmony in the family
- Low socioeconomic status
- Large families and little living space
- Criminal behaviour of parent (mostly father)
- Mental disorder of parent (mostly mother)

Schmidt + Göpel

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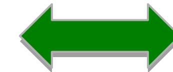
All factors mental disorder

>1 factor risk of mental disorder



1 factor of 5 risk of mental disorder

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Mental Health: Socioeconomic Status and Migration

The KIGGS Study Germany

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- Information about the health situation of children and adolescents
- Method: Questionaires, medical evaluation, interviews
- Period of study: 2003-2006
- 167 locations in Germany
- Age range: 3-17 yrs.
- n = 17.641
- Response rate: 67%

KiGGS
Studie zur Gesundheit von Kindern und Jugendlichen in Deutschland

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Socioeconomic Status

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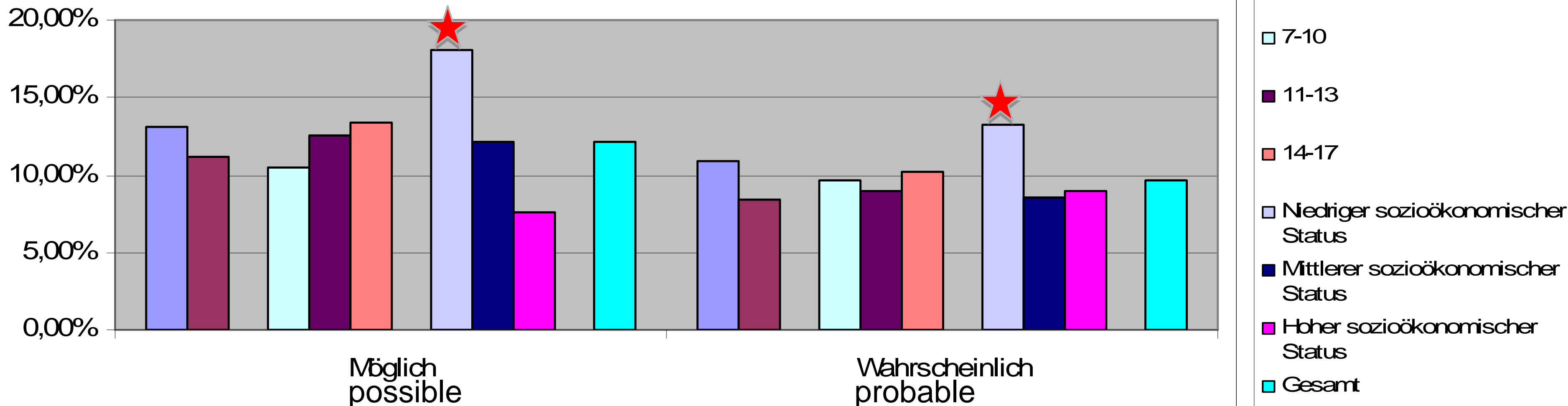

★ Low socioeconomic status is a stronger indicator for the prevalence of mental disorders than age and gender

Socioeconomic Status
Specific Disorders

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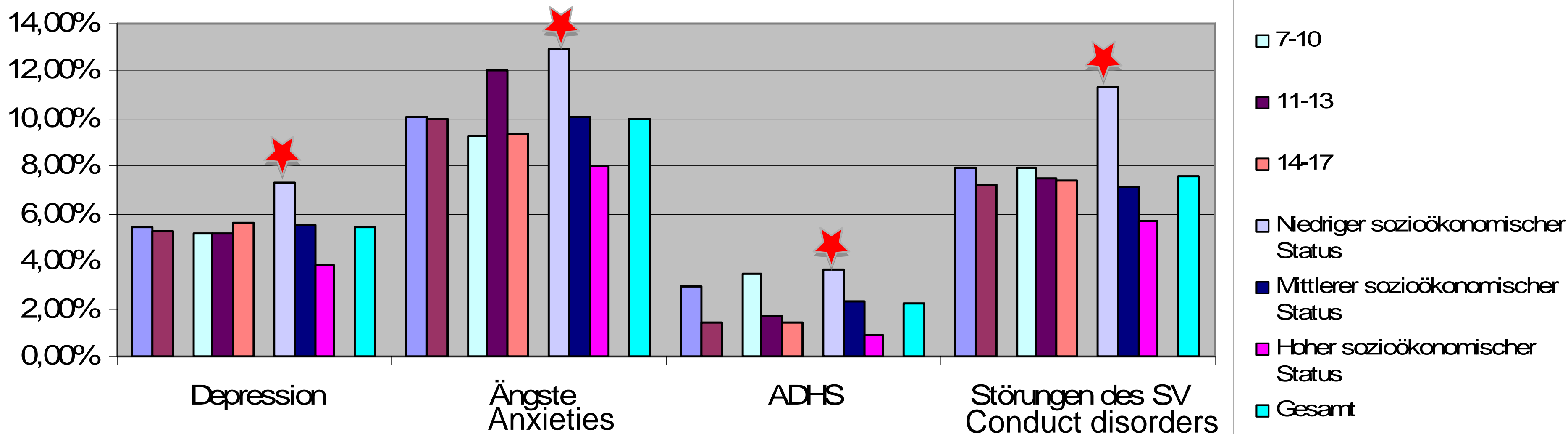

Low socioeconomic status represents a significant risk in developing the most frequent mental disorders in childhooc

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Mental Disorders in Childhood and Adolescence
Ihle und Esser (2002)

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Disorder	Average 6-month Prevalence
Anxiety Disorder	10,4 %
Conduct Disorder	7,5 %
Depression	4,4 %
ADHD	4,4 %
Tics	2,8 %
Enuresis	2,5 %
Enkopresis	0,4 %

Deficits
Socioeconomic Status and Migration

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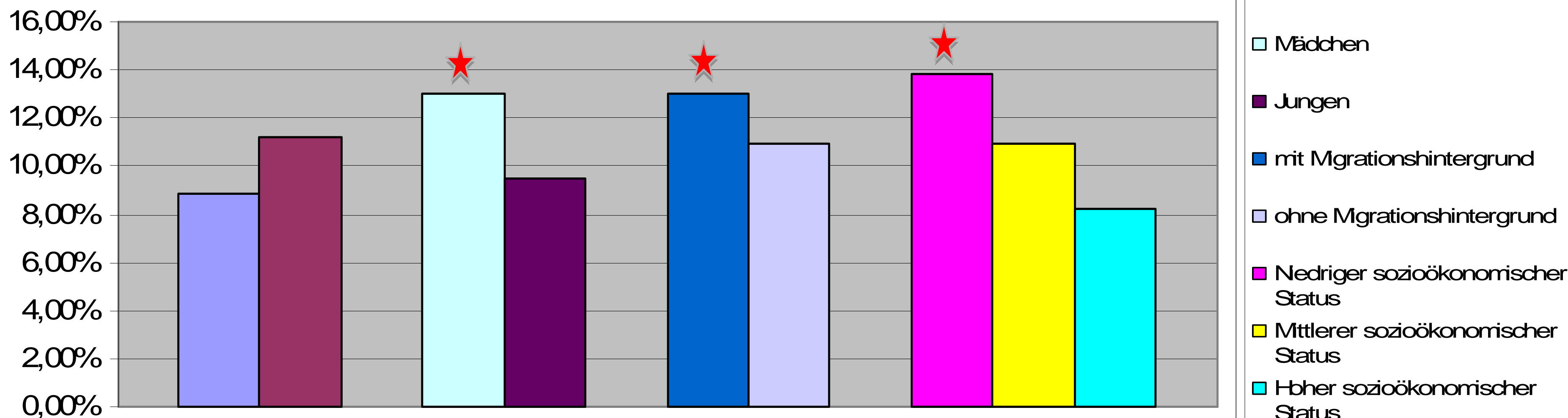

★ Deficits in personal ressources are significant among girls, migrants and children with low socioeconomic status

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Deficits
Socioeconomic Status and Migration

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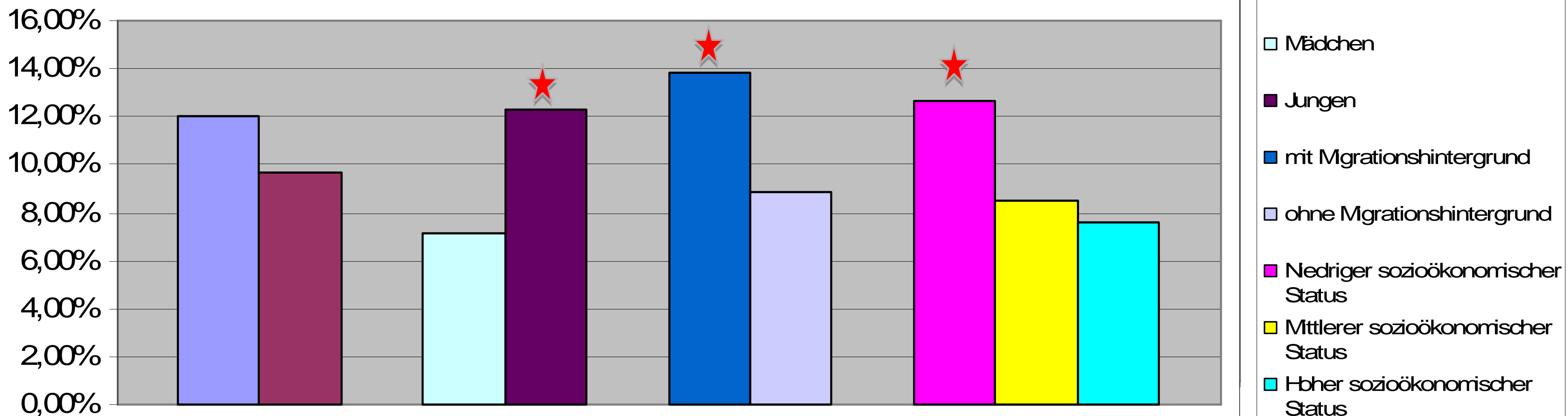

★ Deficits in social ressources are significant among boys, migrants and children with low socioeconomic status

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Deficits
Socioeconomic Status and Migration

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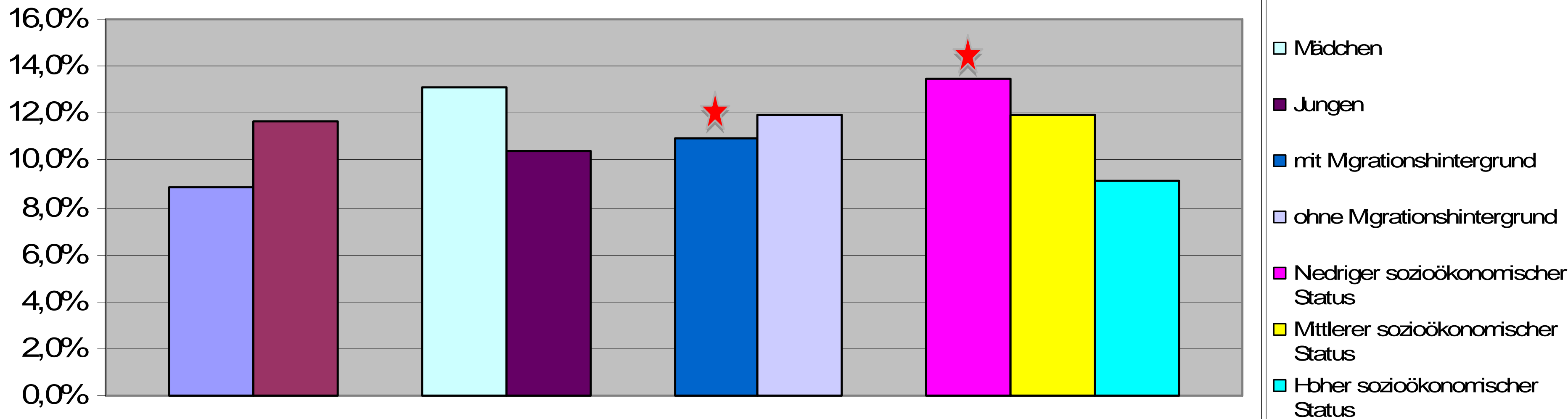

★ Migrants have a slightly better family cohesion
Children with low socioeconomic status show less familiar cohesion

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Summary: Socioeconomic Status and Migration

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- Migrants and families with low socioeconomic status more often show remarkable deficits in their ressources
- Children with migration background more often live in families with low socioeconomic status
- Low socioeconomic status is correlated with the risk of the most frequent mental disorders in childhood

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Prevention Pyramid

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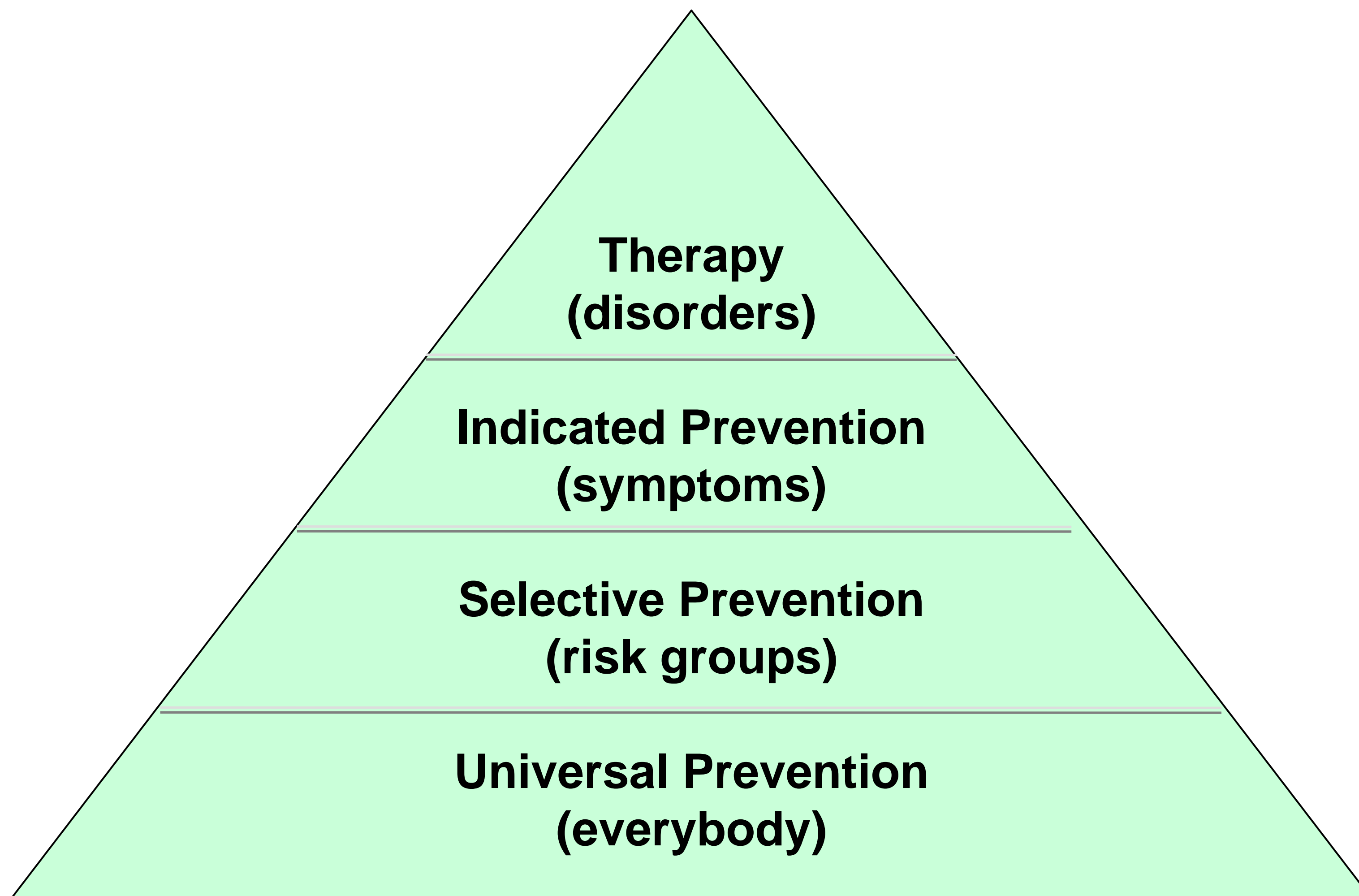

Döpfner, 2006

Prevention Pyramid: examples of good practice

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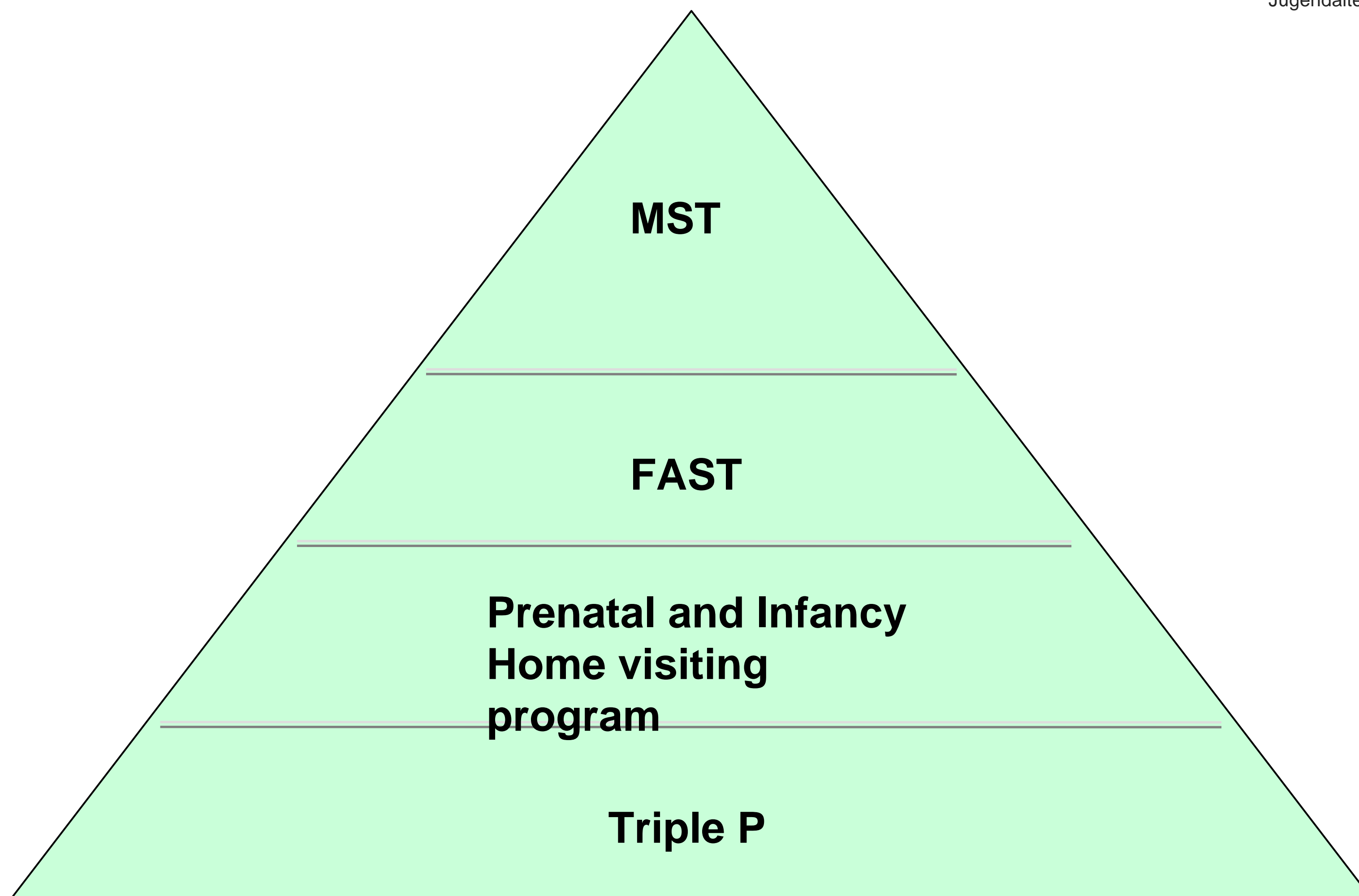

Prenatal and Infancy Home Visiting Program (Olds, 1997, 2002)

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- Pregnant adolescents/low social economic status
  For two years home visits by psychiatric nurses

  Positive effects for newborn:

- Higher birth weight
- Reduction of premature birth (57%)
- Significant reduction of child abuse
- Follow up: after 4 years:
  - Higher maternal employment rate (82%)
  - Less dysfunctional, punishing parenting
- After 10 years:
  - Less alcohol and drug abuse (56%)
  - Improvement of financial situation: Cost effectiveness

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FAST: Family and School Together (Conduct Problems Prevention Group, 1999)

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Multimodal prevention program

- Parent coaching (on saturdays 2 hours „enrichment“)
- Home visits
- Social competence training for children
- Training in school skills, e.g. reading
- Intervention in school classes from year 1-6, e.g. problem solving, anger management

1 year follow up

- ➢ Conduct problems ↓
- ➢ Learning disabilities ↓
- ➢ Reading skills ↑
- ➢ Parents: dysfunctional punishing parenting ↓

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MST Multisystemic Therapy
(Henggeler et al. 1998)

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- Treatment team: 1 supervisor, 3-4 therapist
- Each therapist 4-6 families, each team 50 families per year
- Availability of team 24/7
- Duration of therapy: 3-5 months, 60 hours average per family

- Family focused interventions (e.g. parent coaching)
- Peer group interventions (e.g. integration in prosocial peers)
- School interventions (improvement of school skills)
- Patient/parent focused interventions (e.g. cognitive behavioural individual therapy)

MST Multisystemic Therapy

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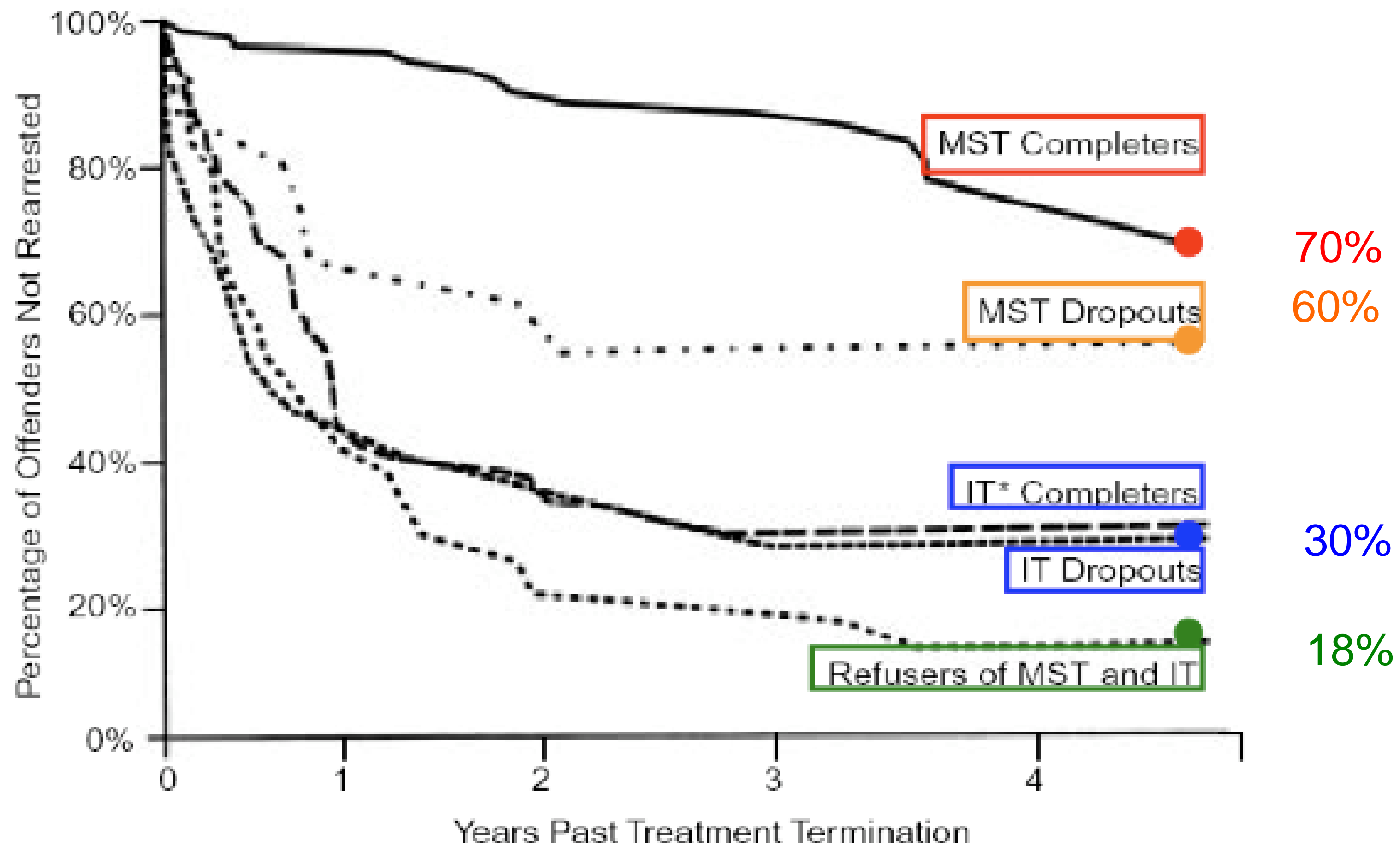

Borduin et al. (1995), Schaeffer&Borduin (2005), MST of serious juvenile offenders: Long term prevention of criminality and violence

Prevention Pyramid: Examples of Good Practice

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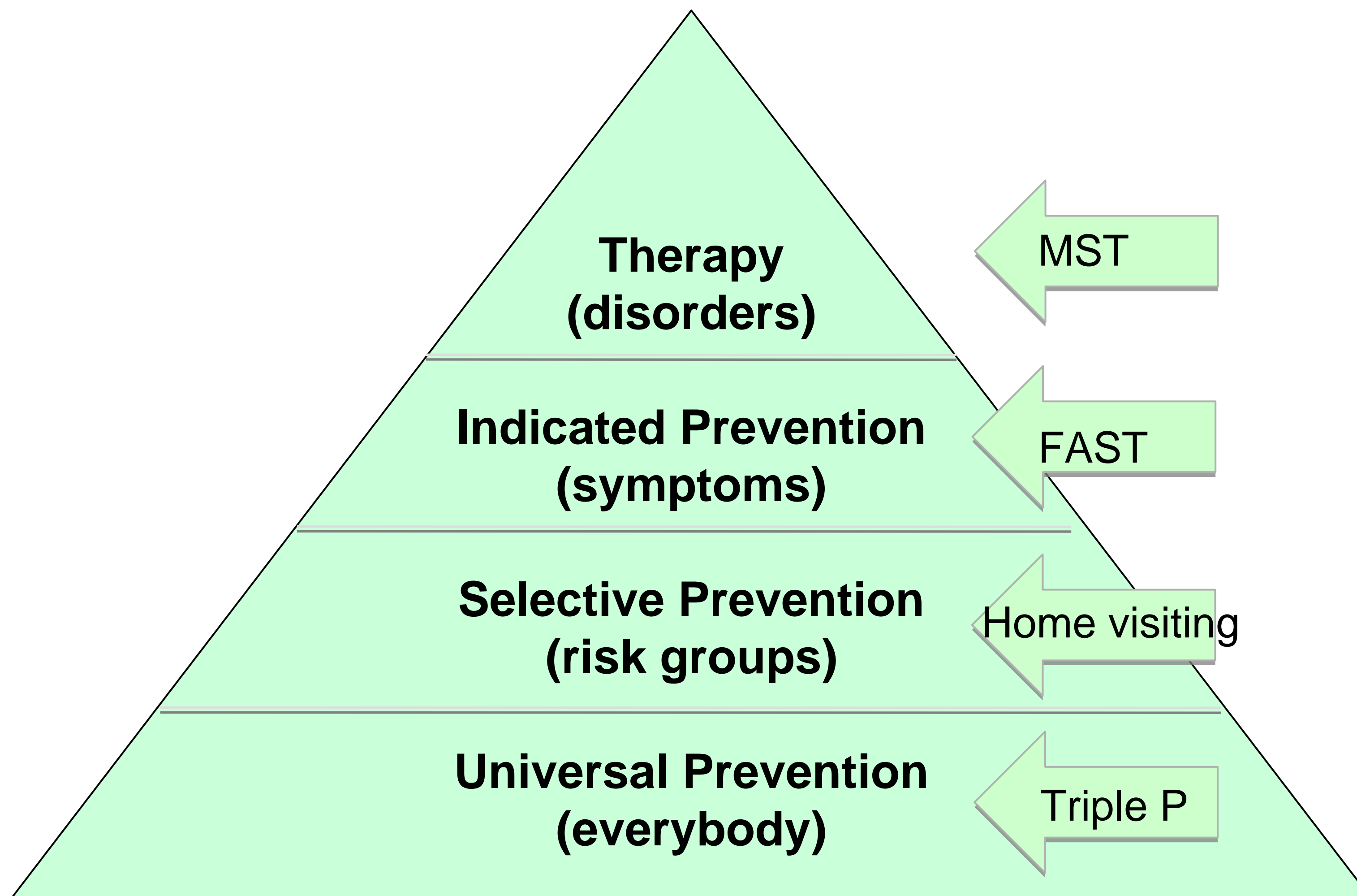

Döpfner, 2006

Tackling Inequalities: Prevention Pentagon

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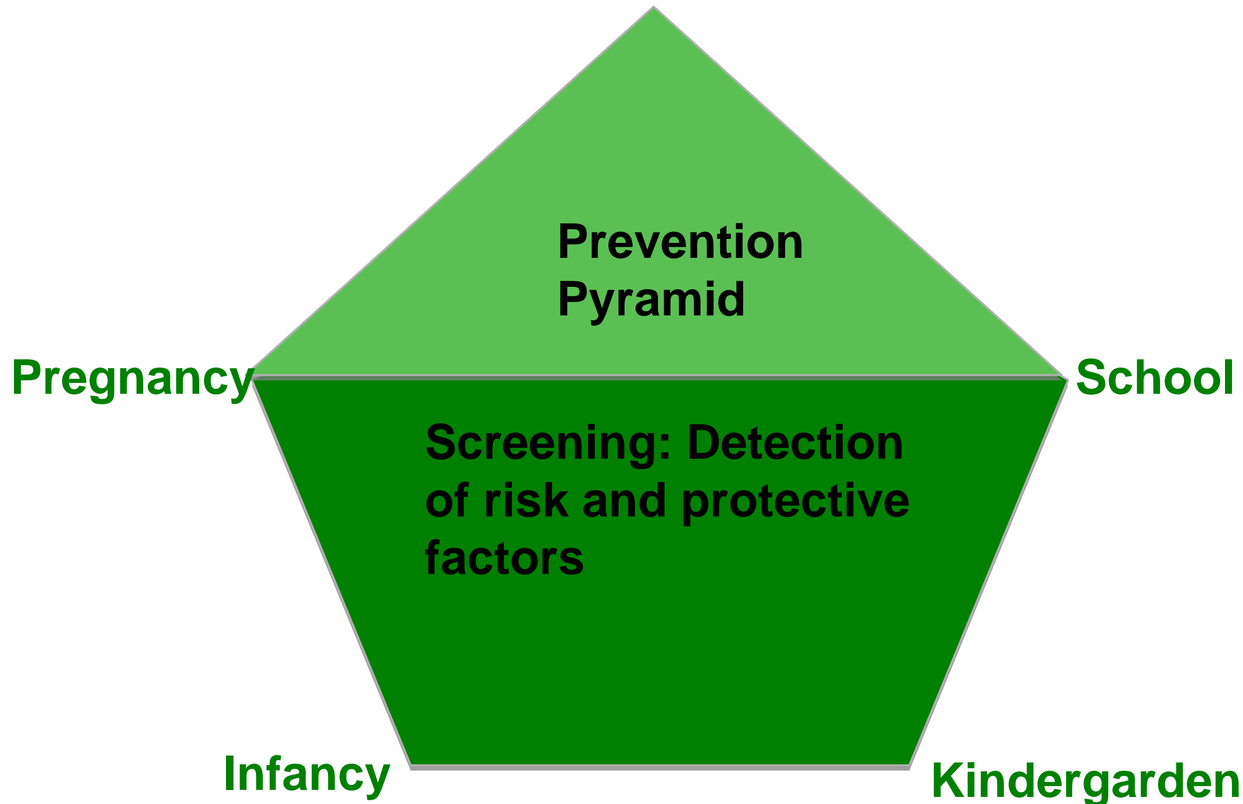

Screening Instruments

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Pregnancy
Questionaires: FPI, PSSI
Home Visit
HRQoL

Infancy
CBCL
Home Visits
Compulsary somatic prevention examinations by pediatricians

Improving network*

Kindergarden
SDQ
CBCL
K-ABC
Conners Scale
Standardized observatory
Behaviour scales

School
Transfer of kindergarden evaluation to the individual school document
SDQ
CBCL
YSR
SCARED (anxiety disorders)
BDI (depression)

*midwife, social worker, teacher, pediatrician, child psychiatrist

Tackling Inequalities: Prevention Pentagon

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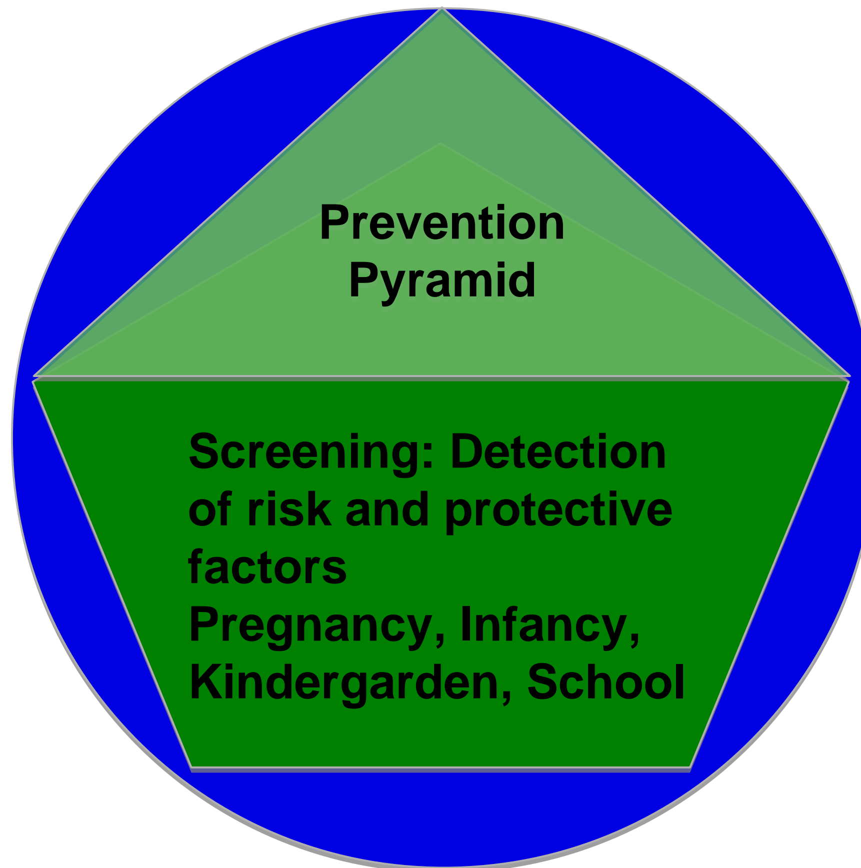

Mobile Integration Team

Mobile Integration Team

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- Child psychiatrist
- Psychologist
- Social worker
- Child psychiatry nurse

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Mobile Integration Team

- Diagnostic screening
- Home visits
- In home treatment
- Crisis intervention
- Network developement
- Coordination

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Mobile Integration Team

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- Hospital based as outpatient service
- Defined area of responsibility per team
- Determined number of families, kindergardens, schools
- Financed by public health care system

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Conclusive Recommendations

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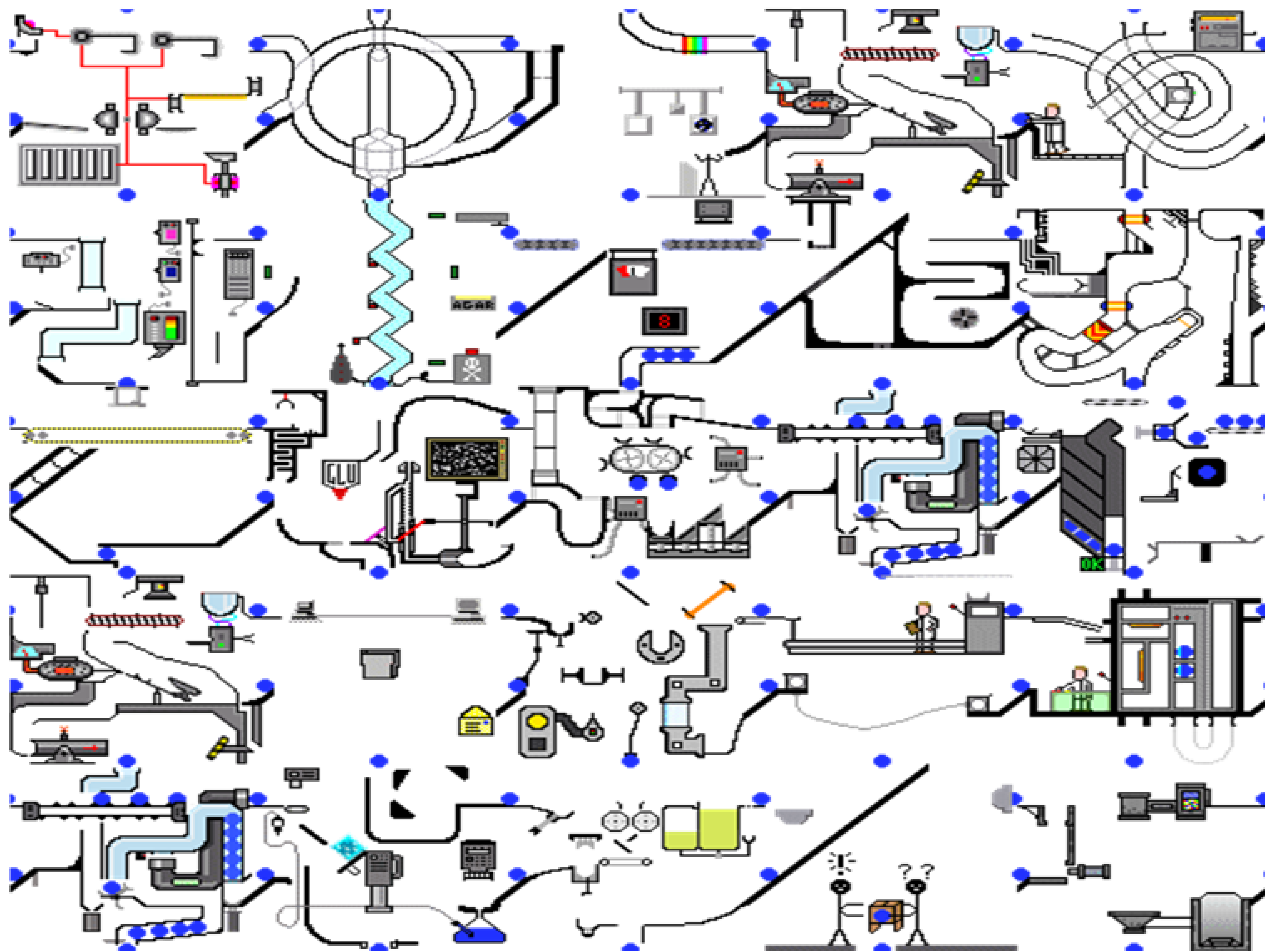
KEEP IT SIMPLE

A Simple Map to Program Development and Implementation

CENTER FOR INNOVATIVE PRACTICES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- Shift of child psychiatric care from hospital to
  - Family
  - Kindergarden
  - School
- Improving inequalities in prevention and treatment by Mobile Integration Team
- Resarch to evaluate optimal choice of screening instruments and cost effectiveness