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RESEARCH ON COMMUNITY-BASED MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

WILLIAM H. FISHER
Editor

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EDITED BY

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CONTENTS

INTRODUCTION: CHILDREN, ADOLESCENTS, AND MENTAL HEALTH SERVICES RESEARCH: AN OVERVIEW OF EMERGING PERSPECTIVE

William H. Fisher

As an undergraduate psychology major, I attended a university in which the psychology department was tilted heavily toward issues of child development. But in my child psychology class, my professor began the course by placing what we know about child development in a historical context. One of our first (and most enjoyable) assignments was to visit our local art museum. Our mission was specific: Look at the faces of the children in paintings from the 16th, 17th, and 18th centuries, and report back. What did we see? We agreed that in at least some of those paintings, children's faces were distinctly "un-childlike." In fact, the children in those photographs often looked like, and were even dressed like, small adults.

What was the purpose of assigning this exercise in art appreciation in a child psychology class? It was to make an important point: that our understanding of children and of the phenomenon of childhood itself, have evolved significantly since those times. The notion that childhood is a distinct developmental stage that the needs of children are unique, the minds of

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children are not the same as the minds of adults, all are products of the early 20th century and largely due to the efforts of early psychologists such as G. Stanley Hall (1905). Had my young child psychology professor (who, incidentally, was now a faculty member in the department that 60 years earlier Hall had helped to found) coordinated this line of argument with what my sociology professor was discussing at the same time, something he called the "sociology of knowledge," this discussion would have been framed in the context of the "social construction" of childhood – the notion that our understanding of phenomena is socially derived and that the actions taken by societies and individuals in any area of life are grounded in those constructions (Berger & Luckmann, 1966). This includes some of our most basic experiences – including the human life span.

We experience the human life span as more or less a "seamless continuum," but the developmental milestones it encompasses have significant ramifications for the larger society. For at least a century, western behavioral science has recognized that childhood, adolescence, adulthood, and senescence are distinct and important periods in which individuals undergo continual and significant cognitive, moral, and social development. This recognition has come to affect the way western societies address the needs of children and in the laws that govern their behavior and the ways in which adults treat them. We understand, for example, that children and adolescents do not possess the same capacity for decision making as adults, even when they may sometimes look and behave like adults. We understand that, their medical needs are different from those of adults, they may be less culpable than adults when they break the law, and they may be vulnerable in a variety of ways that must be recognized when the larger society designs interventions to manage them or even simply allows them to work. All the while, however, we retain a developmental perspective reminding us that, milestones notwithstanding, the lifespan is a continuum in which early events and experiences affect later behavior and actions.

In the medical profession, the salient features of childhood and adolescence led to the growth of pediatrics as a major specialty, and to the founding of "children's hospitals" which catered to the specific medical and psychosocial needs of sick children. As with all medical specialties, pediatrics evolved its own body of specialized knowledge and procedures, as well as its own complement of subspecialties in surgery, cardiology, oncology, endocrinology, etc. Pediatrics evolved its own professional organizations, journals, residency training, and other social trappings of major medical specialties. Even when, in the 1970s, there was an effort abroad in medicine to better integrate pediatrics and adult medicine within the larger

framework of "family practice," the knowledge base and social infrastructure of pediatrics remained intact.

As with physical medicine, "discovery" of the unique features of childhood and adolescent behavior led ultimately to the development of subdisciplines – child psychology and psychiatry, which constructed psychopathology differently as well. As is typical of professional groups, these subspecialties have developed a specialized knowledge base (Freidson, 1970) that has taken the form of a professional construction of age-specific deviant behaviors. Defined as "disorders," these behaviors have been "medicalized" (Freidson, 1970). Codified and subsumed into the diagnostic taxonomy reflected in the *Diagnostic and Statistical Manual's* section on "Disorders of Childhood and Adolescence" (American Psychiatric Association, 1994).

As is also characteristic of medical subspecialties, these professional groups derive and maintain their power and unique status through their ability to apply their definitions of disease to a specific clientele (Freidson, 1970). As such, these disciplines have created and imposed unique definitional categories that are differentiated chiefly by age. Indeed, so pronounced are these subspecialty differences that certain behaviors that seem similar with regard to social presentation and meaning may be given different labels, largely as a function of an individual's age. For example behavioral patterns which include marked violation of social norms may be described as "conduct disorder" for individuals under the age of 18, but will be called "antisocial personality disorder" in adults. While having had the "childhood version" of the disorder by age 15 is one criterion for being diagnosed with the "adult" disorder, and while these behavioral patterns share a status with respect to violation of social norms, they are nonetheless classified separately by mental health professionals.

In the latter part of the 20th century greater recognition of the special needs of children and a general de-emphasis on institutions as solutions to social problems led to the creation of an increasingly differentiated set of public agencies designed to deal with various problems associated with childhood and adolescence. Large orphanages were replaced with a foster care system, overseen in most jurisdictions by a "department of social services." Reform schools were replaced by departments of youth services, and a separate juvenile justice system was created for managing offenders under the age of 18. Indeed, much juvenile offending was given the special status of "delinquency" and special courts were developed for trying cases involving juveniles.

In general, then, it can be said that the care and treatment of children and adolescents has gone forward in a regulatory environment that is much different from that focused on adults. Social welfare policy also views

children and adults differently for a variety of purposes, important among them the determination of eligibility for benefits provided under various entitlement programs. For example, separate regulations apply to women and dependent children with regard to welfare assistance and Medicaid. These differences and their ramifications have been particularly pronounced within behavioral health; children under the age of 18 have been eligible to receive Medicaid reimbursement for extended inpatient treatment in psychiatric specialty hospitals, a service that is denied to older individuals until they reach they age of 64.

The co-evolution of social welfare policy and the definitional regimes of psychiatric/psychological subspecialties with regard to children and adults has led to significant differences in the management of their psychiatric disorders. For the last quarter-century these differences in managerial and treatment approaches have induced significant structural change in a range of organizations, including those administering mental health services. In many locales, public mental health authorities maintain separate inpatient services, residential programs, and arrays of specialized community-based services for children and adults. These differences are reflected in the evolving managerial structures of these agencies, which typically feature a separate managerial and service functions located within a "child mental health" division, which oversees the provision of services to eligible clients under that age group.

This age-based differentiation in mental health service systems can be attributed to a number of factors. One, historically, has to do with the recognition that the large institutions that once housed psychiatric patients of all ages, while in some cases unfit for almost everyone, were particularly inappropriate for younger persons. In Massachusetts, for example, the mid-1980s saw the final push to exclude persons under the age of 18 from adult psychiatric hospitals. This exclusion, of course, necessitated the development of alternative services to meet the needs of individuals in this age group who would have been hospitalized in adult institutions. In addition, federal programs such as Medicaid generated eligibility criteria and funding streams that reinforced the separation of adult and child mental health services.

RESEARCH ON MENTAL SERVICES FOR CHILDREN AND ADOLESCENTS

As we have discussed, recognition of the specialized needs of children and adolescents has taken place late in many domains. The same could be said

with regard to the mental health services research enterprise. Kimberly Hoagwood, a prominent child mental health services researcher and for many years the program officer overseeing the National Institute of Mental Health's services research portfolio in the area of child mental health services research, recently observed that research in this area has lagged behind that for adults by roughly 10 years (Hoagwood, 2005). Indeed, as late as 1999, Burns was calling for the development of a services research agenda for youth with serious emotional disturbances (Burns, 1999).

Arguably, this gap has not been the product of indifference; rather, this delay likely reflects the greater degree of complexity encountered when attempting to "bound" the set of services and service settings that focus on mental health needs of children. Service systems for adults are complex, but, as the chapters of this volume collectively suggest, not anywhere near as complex as those for children. This increased complexity is due, perhaps, to the fact that children routinely and simultaneously traverse a host of such systems and settings – schools, pediatricians' offices, and most importantly, their homes. Mental health problems that may be apparent in one setting may not be as obvious in another, and the consequences of symptom expression in different contexts maybe very different.

The chapters in this volume present a picture, albeit an incomplete one, of this complex array of settings and services, and of the potential effects and prospects of new policies shaping services and approaches to treatment. In the first section of our volume, "Research on Services – from Birth to Young Adulthood" we begin with the most fundamental of relationships – the mother–child unit. Sarah Horwitz, Julia Bell, and Rebecca Grusky provide an overview of the current approach to identifying and treating postpartum depression. They argue that some of the same settings in which infants and toddlers are treated could be ones where depression in their mothers might be detected. Other settings, such as the workplace, could serve this purpose as well. Clearly, while the focus of such treatment is an adult mother, the implications for the well-being her child are critically important. But as Horwitz and her colleagues indicate, this spectrum of services and settings largely fails in this regard.

One of the problems facing researchers striving to understand the scope of the mental health needs of children is the multiplicity of settings in which those needs are identified and addressed. None is more important than the school. Going to school is what most children "do." For many it represents their first official foray into a world in which social, functional, and emotional demands will be placed on them. Increased sensitivity to these needs, coupled with legal mandates to provide special education services, has made

the school a key mental health services outpost for many children. Melissa Pearrow and Peter Whelley, a school psychologist, provide an overview of the challenges facing public schools in fulfilling this mission, a challenge that includes the need to interface the schools services with those of other system entities.

As we noted earlier, public policy has evolved toward a system of separate entitlements for children and adults. While the appropriateness and good intentions of such a bifurcation are unassailable, there are, nonetheless, problems that arise at the boundary of childhood and adulthood. This age-driven differentiation has led not only to the development of different service provision mechanisms for children and adults, but also to different eligibility criteria for receiving those services. Put simply, children diagnosed with one of the range of "serious emotional disorders" found in the child psychopathology taxonomy may be eligible to receive a broad array of services from their state mental health agency until their late teens – typically until the age of 18. But, while these disorders do not "magically disappear" on one's 19th birthday, eligibility for receiving services from the state mental health agency, including access to residential and other critical support provided by that agency effectively ends. This occurs because, after age 18, individuals are deemed eligible for state mental health agency services based on a different set of criteria, a protocol which usually requires that one be diagnosed with one of the major *adult* psychiatric disorders, such as schizophrenia. Thus, while their mental health and related problems persist, their supports effectively end. That this represents a significant failure of policy should seem obvious, but until recently this problem had not been a focus of discourse for mental health policy or services researchers. In "The Great Divide: How Mental Health Policy Fails Young Adults," authors Maryann Davis and Nancy Koroloff address this issue. Specifically, they provide data on service eligibility policies in 46 states to determine the extent to which current policies affect the continuity of services for youth in child mental health systems as they transition from adolescence to adulthood. Their policy analysis demonstrates that each state's child mental health policy differed from its adult population policy, generally in the direction of more narrow adult criteria.

In Part II, "Evaluating and Examining 'Systems of Care,'" we present three chapters that examine one of the central concepts in contemporary mental health services delivery for children and adolescents – the "system of care" (Stroul & Friedman, 1986). If the African proverb "It takes a village to raise a child" is true, it would appear that it takes a multi-faceted, multi-setting system to care for a child with emotional disorders. In this section of

the volume we present three chapters focusing on evaluation and assessment of systems of care. David Mandell, James Guevara and Susmita Patel describe a new system entity, the "medical home," and compare it with the system of care model. The paper provides a useful overview of the evolution of thought that created the current approach to providing multi-disciplinary approaches to caring for medical and psychological treatment needs of children. It also points out the need, endemic in mental health services design, for those creating the medical home model to learn the lessons obtained through the creation of the system of care model.

Applying the term "system" to a collection of providers naturally invites the question of whether services are coordinated and actually "appear as a system" from those embedded within it. This question is addressed in the chapter by Denine Northrup, who applies the widely used network analysis approach to evaluate service system configuration. The paper is heuristic as well as evaluative, useful describing how the evolving network analytic methodology can be used to examine critical issues in the complex of providers and agencies seeking to meet the needs of young persons with mental health needs.

How large is a locale's system of care? How many children are served? How do we measure demand for services when children can be seen in so many different settings? In their chapter, John Pandiani, Christine VanVleck, and Steven Banks offer a methodological approach to this problem using the large administrative databases maintained in most jurisdictions but rarely combined to examine this issue. Using probabilistic approaches, they show how the number of individuals served in multiple facets of the system of care can be examined without violating the stringent safeguards on data privacy recently imposed by the Health Information Privacy and Protection Act.

In the third and concluding part of the volume, "Systems of Care and Evidence Based Practice: Theoretical and Conceptual Issues in Research and Policy Analysis," we present three papers which explore conceptually the system of care model, the use of evidence-based practices, and their relationship. Two papers, one by Tracy Pinkard and Leonard Bickman and another by Kathleen Biebel and Jeffrey Geller, discuss how well systems of care and other conceptually driven service models fare in the new policy environment that emphasizes evidence-based practices. Rosenblatt and Campion, in the volume's final chapter, describe methods by which research on systems of care and research on evidence-based practice can be integrated. While these papers collectively address issues in the delivery of mental health services to children and adolescents, many of the issues they raise are not peculiar to that treatment system alone; indeed many of these issues pervade the entire mental health policy and services research arena.

Together, the papers in this volume present the services research community a thoughtfully derived set of conceptual issues and systems analyses which should help in the further honing of a research agenda for examining critical areas of service delivery for children and adolescents, appropriately integrated services, and necessary continuity. Any such agenda should also recognize the importance of the "non-specialty sector" – providers of treatment such as schools, primary care pediatrics and the juvenile justice system, and determine these providers the other services with which their clientele come into contact.

This volume has several important omissions. For example, recent studies indicate that a substantial number of the youths detained in juvenile justice settings have serious emotional and substance use disorders (Grisso & Underwood, 2003). There has been in this system an increased emphasis on screening for such disorders as well as honoring the constitutional rights of correctional detainees to medical and psychiatric care. How this treatment is integrated with that provided by the locales' broader system of care and how youthful detainees with mental health needs are linked to those systems upon their release is but one of many key issues for future mental health services research efforts. We have not included a chapter on this topic, and clearly one should be present.

If, as Kimberly Hoagwood observed, research on services for children and adolescents has lagged behind that focusing on adults, there is clearly important work ahead. As this collection of papers suggests, research in this area is fascinating for its scope, its multi-actor and multi-system features and critically important because of the precious population toward which these services are geared.

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