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In 1969 the Joint Commission on Mental Health of Children conclud- ed that the status of mental health services for children was clearly inadequate “on all levels, rich and poor, rural and urban. . . . [O]nly a fraction of our young people get the help they need at the time they need it.”¹ Children experience emotional difficulties that vary considerably in type as well as severity. These problems range from serious depression to moderate anxieties and fears, and from highly aggressive behavior to noncompliant behavior of a more passive nature. The consequences of these problems may include suicide, serious harm to others, and an inability for some young people to live with their families. Some of these problems may be a reaction to temporary environmental stressors, while others (particularly the most serious problems) are part of a long-term pattern of difficulty in functioning effectively. It is estimated that up to 20 percent of all youth have a diagnosable mental disorder at any one point in time, and both the prevalence and the severity of these problems are increasing.²

Children with serious emotional problems, their families, and the services provided to them have received a marked increase in attention since the mid-1980s. Led by the Child and Adolescent Service System Program (CASSP) of the National Institute of Mental Health (NIMH), initiated in 1983 and awarded its first grants in 1984, a new vision of service provision for children and adolescents and their families has emerged.³ This vision emphasizes the need to develop community-based systems of care based on a set of values and principles and the best available research. These systems of care, which have been implemented intermittently across the country, incorporate a range of services; involve several agencies; forge new partnerships between parents and professionals; and provide intensive, individualized, and “culturally

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competent” services. They are based on the belief that parents should be supported in their efforts to keep their families intact, that services should be provided in the least restrictive setting that is appropriate to meet a child’s needs, and that through flexible and individualized services it is possible to reduce an overreliance on out-of-home placements. The experiences of numerous states and communities attest to this.

Despite this increased focus, there is an enormous discrepancy between the conceptual model of what a system of care should be, as embraced by state policymakers, and its actual implementation at the grass-roots level. An enormous discrepancy also exists between the number of youngsters and families in need of services and the amount of actual services available. Similarly, there is a gap in implementing the philosophy concerning the role of parents, in developing culturally competent systems of care, and in implementing innovative and individualized services. Overall, a series of reports from individual researchers and government agencies have all concluded that while some progress has been made, children with emotional disabilities and their families remain an underserved and ineffectively served group of individuals facing many challenges.

This Commentary addresses child and adolescent mental health from two perspectives. First, we describe the present status of young people and their families and analyze the status of services to prevent and treat emotional disorders in children and adolescents. Next, we discuss the challenges facing the field, as well as some of the current efforts to overcome these challenges.

Status Of Young People And Their Families

The first question to be asked concerning the status of child and adolescent mental health pertains to the prevalence of diagnosable emotional or mental disorders. Programmatic research to estimate the prevalence of mental disorders in children has not matched the research into adults’ mental disorders, although such a research program is currently beginning under the sponsorship of NIMH.

Based on a review of studies from the 1980s, Nancy Brandenburg and colleagues have estimated that 14 to 20 percent of children have a diagnosable disorder at any point in time. Jane Costello has presented a range of 17.6 to 22 percent, based on a review of a slightly different group of studies. These estimates represent an increase from the more traditionally used prevalence rate of 11.8 percent offered by Madelyn Gould and colleagues for the President’s Commission on Mental Health in the late 1970s. There are indications that the increase in rates may be
even greater, however. For example, Lee Robins used data from the Epidemiological Catchment Area (ECA) study in St. Louis to compare prevalence rates for conduct disorder across successive age cohorts. It was possible to conduct such an analysis because subjects in the study had been interviewed about particular behavioral problems as adolescents. Based on this analysis, Robins estimated the prevalence rate for the youngest age group in the ECA study (adults ages eighteen to twenty-nine) to have been 22 percent for males when they were teenagers and 13 percent for females. He concluded that the prevalence of conduct disorder in both males and females has increased substantially.

In reflecting on changes over the years, Felton Earls stated that “cultural changes in the United States also seem to have brought on new vulnerabilities in children, reflected in higher rates of complete suicide and an early age of onset for some types of psychiatric disorder. . . . Bipolar affective disorder, a disorder with an average age of onset in the late [twenties] according to previous clinical experience, has now become a regularly occurring disorder in adolescents. Major depressive disorder is now recognized in preschool children, anorexia nervosa in prepubertal children, and the average age of onset of alcoholism has shifted from the late [twenties] to the early [twenties] over the course of not much more than a decade. Moreover, alcohol and drug abuse have become major problems among . . . young adults of all social classes.”

The increased prevalence and seriousness of problems and the earlier age of onset is compounded by changes in the familial, social, and cultural supports for children. The heightened strain experienced by families is perhaps best reflected in changes in reported cases of maltreatment of children nationally. As the U.S. Advisory Board on Child Abuse and Neglect reports, while there were about 60,000 reported cases of maltreatment nationally in 1974, that number increased to 1.1 million in 1980, and by the end of the 1980s was up to 2.4 million. In a report of the U.S. House Select Committee on Children, Youth, and Families, Rep. George Miller (D-CA) stated that “if current trends continue—and they most likely will—the number of children living in foster homes, hospitals and detention facilities may jump from nearly half a million right now to more that 840,000 by the year 1995.” These figures reflect the fact that many families, particularly those in poverty, are experiencing multiple problems in several aspects of life.

The increasing prevalence of a constellation of what appear to be interrelated problems has led to a new diagnostic category, which Lisbeth Schorr calls “rotten adolescent outcomes.” This refers to a cluster of outcomes such as dropping out of school, substance use, teen pregnancy, emotional disorders, aggression, and delinquency, which she
indicates can often be traced to similar risk and protective factors. Recent advances in longitudinal research and in the fields of developmental psychopathology and developmental epidemiology have given rise to concepts such as “developmental pathways.”\textsuperscript{15} This research seeks to determine the risk and protective factors at different developmental stages and to identify the pathways by which these factors lead to particular outcomes. Work by Rolf Loeber and his colleagues, for example, illustrates how such factors as exposure to neurotoxins, temperamental dispositions, and attentional problems without appropriate protective factors can often start a child on a pathway leading to significant oppositional behavior, antisocial behavior, and substance abuse.\textsuperscript{16} The 1990 Office of Technology Assessment (OTA) report on adolescent health also reflects a recognition of the interrelatedness of many problems.\textsuperscript{17} In this regard, the OTA explicitly takes a holistic approach to adolescent health, focusing not just on physical health and mental health but also on related issues of violent and aggressive behavior, educational performance, and delinquency.

\textbf{Status Of Services For Children And Adolescents}

The increased recognition in the 1980s of the seriousness of emotional disorders in children and adolescents led to the development of community-based systems of care. Before such systems of care emerged, there were few service alternatives for children other than office-based outpatient treatment (usually for no more than one hour per week) or some form of out-of-home care, in either a residential treatment center or a psychiatric hospital. Now, more communities are finding that services such as intensive home-based treatment, day treatment, clinical case management, wraparound care, respite care, parental support groups, and therapeutic foster care can provide the intensity, quality, and comprehensiveness of services to reduce the need for placements in residential treatment centers or psychiatric hospitals.

\textbf{Barriers to community-based care.} As such community-based systems of care develop, three major barriers become apparent. The first barrier, which perhaps was easiest to anticipate, is the difficulty in breaking through traditional ways of operating. This includes getting agencies that are accustomed to working independently to work collaboratively, changing attitudes and practices of professionals toward parents, getting mental health professionals to reach beyond their offices to provide services, training professionals to provide culturally competent services, and modifying fiscal policies so that they support individualized and family-based care. The second barrier is the unanticipated increase
in demand for services, arising from the increased prevalence and seriousness of problems, the heightened strain that families are experiencing, and the large number of families requiring multiple supports and services. The third barrier, also unanticipated, has been the shrinking pool of resources because of governmental budget problems.

Themes for reform. Policymakers are recognizing that simply securing a few more dollars will not get the job done and that significant system reform is needed. The major themes for this reform involve the following: decentralization of control from state to county to community; increased flexibility of funding through reducing the number of discrete funding categories, each of which has separate eligibility requirements; changing fiscal policies to support individualized and family-based services and to provide incentives for home and community-based treatment; moving beyond interagency collaboration to provide integrated services in recognition of the multiple needs of families; gradual reallocation of resources so that the system, rather than waiting until problems get severe before intervening, emphasizes family support, prevention, and early intervention; greater participation of consumers and family members in planning and policy development; increased family focus in providing supports and services; increased partnerships between policymakers and providers not only with parents but also with the business community and civic, service, and religious organizations; increased emphasis on reaching out to minority groups; and stronger linkages between schools and health, mental health, and social services.

Historically, our systems have been based on the implicit assumptions that very few children need special services, that resources are adequate to wait to serve those children until their problems get severe, and that the problems of children and families are largely single-dimensional (health, educational, or economic, for example). Now, as the numbers of children needing help are increasing, as the interrelatedness of problems is becoming more apparent, as the multiple needs of families are becoming more obvious, and as resources are becoming less adequate, the basis for major system reform has been established.

At the same time, the number of inpatient beds for children and adolescents in the private, for-profit sector has grown at unprecedented rates. Between 1980 and 1986 there was a 154 percent increase in admissions of children to private psychiatric facilities.\(^\text{18}\) Data for 1986 reveal that 41 percent of persons under care of and 20 percent of admissions to private psychiatric hospitals were under eighteen years of age.\(^\text{19}\) Data also indicate that the mean length-of-stay of children and adolescents is up to 50 percent longer than that for adults, making children and adolescents a particularly expensive population to treat.\(^\text{20}\)
The enormous increase in use of private for-profit psychiatric hospital beds is obviously related to a number of financial and marketing factors. This increase has been accompanied by strong complaints that youngsters were being admitted inappropriately, served inadequately, and had their stay in the hospital controlled by the coverage limits of their insurance policy rather than by actual need. Analysts called on insurance companies to develop more flexible benefit designs so that newer services could be included. There were also calls to develop adequate protections for children and families to ensure that hospitalization is used only when necessary and only for as long as is needed.

In many ways, the public sector—not always viewed in the most positive light—led the way in the 1980s in developing a range of innovative services and in providing services according to a set of values, including built-in protections that safeguard the rights of children and families.

Challenges Facing Child And Adolescent Mental Health Care

Given this perspective on the status of children and adolescents and the status of service systems, we offer a brief discussion of four major challenges facing the health care field in the area of child and adolescent mental health.

First, the health care field must reorient its thinking and practice in recognition of the enormous and multiple needs of children and families and the interrelatedness of problems in the mental health, health, education, substance abuse, delinquency, teen pregnancy, and vocational domains. Essentially, this means that at a time when overall health care practice has evolved to heightened specialization, there must be increased emphasis on family support and on the relationship between physical health, mental health, and all other key areas of functioning. It should no longer be the case that the whole is fragmented into many separate parts. The role of pediatricians, as the primary care physicians for most children, becomes critical and must include a strong focus on both psychosocial and physical well-being and on the well-being of the entire family, not just the child who is being examined.

Second, the mental health care field must face the challenge of providing proper financing to support flexible, individualized home and community-based care and must cease to create fiscal incentives for hospital care. Obviously, there is considerable movement in this direction, specifically in managed care but also in indemnity insurance. At a time when national attention is directed to both the status of the health care system and the status of children and families, there is a wonderful...
opportunity to contain costs and better support children and families through redesigning benefit packages.

Third, the growth of the private for-profit psychiatric hospital industry and the complaints about unethical and improper practices represent a special challenge. It is essential for the health care field to exercise strong leadership to ensure that children are not the innocent victims of profit-driven practices. This is not to deny that within community-based systems of care there is an important role for inpatient psychiatric hospitalization. However, there is clearly a need to provide proper protections so that children are only admitted when needed; that they and their parents have the best information available about options; that treatment, when needed, is of high quality; and that youngsters do not get unceremoniously “dumped” when their insurance coverage runs out.

Fourth, the health care system must become part of multisystem partnerships and public/private partnerships to create the types of conditions in our communities that will reduce the incidence of problems and allow children and families to thrive. As greatly respected members of our communities, health care professionals and health care organizations must set aside their own specific concerns and work in partnership with others to create an overall healthier environment. Unless this is done, not only the health care system will bear the burden of a continued escalation of problems, but so will the country as a whole.

### Efforts To Address Challenges

Significant efforts are under way around the country to address some of these challenges. The following review highlights some current efforts to reshape service delivery.

**Integrated, community-based care.** A number of states and communities have tried to create more integrated and effective community-based systems of care. One of the best models is the Ventura Planning Model based on the Children’s Demonstration Project located in Ventura County, California. This model has five basic components, which present a framework for planning systems of care: a clearly defined target population; a systemwide goal; interagency coalitions; treatment services and standards; and systems monitoring and evaluation. This system is noteworthy not only for being multiagency but also for establishing quantifiable goals and objectives as well as an ongoing practical system of monitoring and evaluation. California is currently attempting to replicate the Ventura Planning Model in three other counties.

**Changing financial structures.** Many states and communities have also undertaken efforts to modify financial structures in attempts to
reshape service delivery systems. Iowa, for example, has sought to modify fiscal incentives and increase flexibility by dramatically reducing the number of separate funding categories in the child mental health, child welfare, and juvenile justice arenas and by making one county agency accountable for overall services. Virginia is also launching a significant effort at decategorization with plans to blend nine funding streams from mental health, juvenile justice, child welfare, and education with an initial focus on reducing the funding categories for out-of-home placement, placing greater control at the county level, and creating financing incentives for counties to serve children in their communities. These efforts and others document the growth in designing innovative financing mechanisms to reshape service delivery systems. The underpinnings of the innovative financial mechanisms include maximizing Medicaid benefits to increase mental health services to children, blending categorical funds from the traditional child-serving agencies, increasing the flexibility of funds to meet the needs of the individual child and family, and increasing local control over financial resources.

**Links with schools.** There are several noteworthy efforts to link schools more closely with a range of health, mental health, and social services. New Jersey has been a leader in this, while states such as Florida, Missouri, and Pennsylvania have also launched major efforts at creating more integrated services, with schools serving as a hub.

**Private foundation initiatives.** Several private foundations have launched major initiatives in recent years to promote system reform. The Robert Wood Johnson Foundation has implemented a major eight-site child mental health initiative, with a primary focus on expanding the range of services available to support children and families, creating multiagency partnerships, and modifying fiscal policies so that they are more supportive of individualized and home-based care. The Robert Wood Johnson Foundation also has initiated a child health initiative that focuses on holistic services, use of flexible funds to provide comprehensive and individualized care, and regular data collection on the well-being of children. The Edna McConnell Clark Foundation has specifically focused on promoting family preservation services. They charge that “children are separated from their families by default. Too few alternatives are available to help them stay together safely.”

The Annie E. Casey Foundation is beginning a child mental health initiative that focuses specifically on poor inner-city neighborhoods. This program will have a strong focus on system reform, with a special emphasis on fiscal reform and on developing a set of family-based services ranging from prevention to early intervention to treatment. It represents a dramatic shift from county-based services to neighborhood-
based services, and from services for a limited population to services for
the entire population of children and families, at varying levels of
intensity, in the neighborhood. This foundation also conducts a “Kids
Count” program on a national level and within about twenty states.
Through this program, data on indicators of well-being of children are
collected regularly to track progress and to provide an empirical base for
service and policy development. The David and Lucile Packard Founda-
tion has created the Center for the Future of Children. One of the early
products of this center has been a monograph specifically looking at
efforts to link schools with health and social services.

Hospitalization. Within the specific domain of psychiatric hospitali-
zation, several states are seeking to provide better protections for chil-
dren. North Carolina, Texas, and Virginia have passed legislation to
provide increased protection for children, while New York and Ohio
have tried to prevent excessive growth by strengthening their proce-
dures for obtaining certificates of need.

One of the more exciting efforts to address the issue of providing
coverage for a broader range of services is a unique project funded by the
CHAMPUS program of the Department of Defense and operated by the
state of North Carolina and Fayette County in the Fort Bragg area.
Through this program, children who are CHAMPUS beneficiaries are
eligible to receive whatever types of mental health services are required,
rather than being restricted, as CHAMPUS typically does, to outpatient
care, residential treatment, and inpatient hospitalization. The potential
benefit of this program is enhanced by the fact that a rigorous inde-
dependent evaluation is being conducted by Leonard Bickman and his
associates at Vanderbilt University. Preliminary results of the evalu-
ation are beginning to document the efficacy of community-based treat-
ment for youth with serious emotional or behavioral disorders.

Managed care. Managed care has grown as a strategy for controlling
costs, reversing fiscal incentives, and in some cases providing coverage
for a greater range of services. In addition to health maintenance organi-
izations (HMOs) and preferred provider organizations (PPOs), there now
exists a new breed of organization best described as a “case management
organization” (CMO). These CMOs specialize in combining one or
more of the various mechanisms into a service product to be sold to
insurers and employers. Many CMOs specialize in specific disorders and
populations, such as child and adolescent psychiatric care.

The impact of managed mental health care on children and adoles-
cents was studied in the Tidewater area of Virginia. Under this pro-
gram, there was a clear shift away from use of inpatient psychiatric
hospitalization and toward greater use of outpatient care. Although
shifts in utilization patterns and cost savings could be documented, the impact on the recipients of service could not be determined.

In the specific area of children’s mental health, an example of a provider combining managed benefit plans with case management services is Wiley House, a national nonprofit provider of psychiatric services for children and adolescents with headquarters in Pennsylvania. They have designed flexible benefit packages for large insurance companies, which include coverage of community-based treatment services such as intensive in-home treatment and intensive family treatment (based on a therapeutic foster care model), as well as step-down programs for children who are leaving inpatient care. While such flexible benefit plans for children and adolescents are just beginning to be accepted by insurance companies, they have great potential as alternatives to the traditional restrictive policies that often create incentives for hospital care.36

Conclusion

This is clearly a time when the challenges facing the health care field in the area of child and adolescent mental health are great, whether viewed from an epidemiological, family, systems, or economic perspective. Such a time calls for strong leadership willing to explore the feasibility and desirability of significant change from standard operating procedures and able to look beyond the specific needs of one’s own organization or field.

The health care field has both a great stake in improving the overall status of children and families in our communities and a great potential to contribute to that improvement. Significant challenges confront all people interested in the well-being of children and families, and although there are a number of encouraging responses to these challenges, there clearly is room for more.

NOTES


16. Loeber, paper on conduct disorder.
25. Iowa Department of Human Services, Polk County Board of Supervisors, and Polk County District Court, Polk County Decategorization Project Annual Report (Des Moines: Department of Human Services, 30 November 1990).