REDRESSING THE EMPEROR

Improving Our Children's Public Mental Health System

John S. Lyons

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Contemporary Psychology
Chris E. Stout, Series Editor

PRAEGER

Westport, Connecticut
London

Library of Congress Cataloging-in-Publication Data

Lyons, John (John S.)
Redressing the emperor : improving our children's public mental health system / John S. Lyons.
p. cm. — (Contemporary psychology, ISSN 1546–668X)
Includes bibliographical references.
ISBN 0–275–98143–6 (alk. paper)
1. Child mental health. 2. Child mental health services. 3. Children—Mental health. 4. Public health. I. Title. II. Contemporary psychology (Praeger Publishers)
RJ111.L96 2004
362.2'083'0973—dc22 2004000481

British Library Cataloguing in Publication Data is available.

Library of Congress Catalog Card Number: 2004000481
ISBN: 0–275–98143–6
ISSN: 1546–668X

First published in 2004

Praeger Publishers, 88 Post Road West, Westport, CT 06881
An imprint of Greenwood Publishing Group, Inc.
www.praeger.com

Printed in the United States of America

The paper used in this book complies with the Permanent Paper Standard issued by the National Information Standards Organization (Z39.48–1984).

10 9 8 7 6 5 4 3 2 1

To Melanie
My inspiration and my anchor

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Foreword

In one of my past professional lives, I worked as a psychiatric technician for an inpatient psychiatric children's unit, on my way to becoming a clinical psychologist with a specialty in children and families. I have also worked as a child psychologist (and later as executive clinical director) in a therapeutic day school where metal detectors and confiscated weapons were the norm. I have worked in public systems for youth as well as private practice, managed-care settings. Thus, I have been spit on, cursed at, lied to—you name it. I have conducted and published a moderate amount of research on the diagnosis and treatment of differing disorders in children. Thus, with a modicum of clinical, scientific, and administrative experiences in public, educational, and private settings, it was with a great deal of anticipation that I read the early draft of this work.

I can tell you, I was not disappointed.

Although it may be easy for some critics to take potshots at the magnificently flawed, faltering, and fragmented approaches to providing care for children in need, John Lyons avoids the easy temptation of joining in with the howls of dinosaurs, and instead delivers an inspired vision supported with pragmatic solutions and principles—but without now familiar bromides.

Lyons devotes much of this work to providing the reader with the concepts for understanding the historic nature of the current circumstances. In addition, half of this work pragmatically offers a

tool-supported vision for the next phase of development that wisely includes prevention and community development (inclusive of all aspects), and he offers up this ratchet of progress in what he terms Total Clinical Outcomes Management. This informed approach is not some new nostrum, but I believe it can serve as a galvanizing totem of real inspiration. His approach provides readers with a unique, but genuine, alchemy of ideas and method.

His frank examination of national trends and circumstances provides a cohesive and coherent contextual understanding in the context of a rich and enlightening texture, without being a tedious read. He does not avoid the additionally complicating factors of racial disparities, cultural competency, or stigma. Limitations of model generalizations and naive expectations of transportability or magical scalability are called into question. Disappointing, formerly touted magic bullets are exposed to the light of day as duds. Peppered throughout the book are real experiences and situations, with wise examination and critique highlighting the exquisite frustrations involved in working with systems intended to help but that instead, may iatrogenically do more harm.

His edgy and refreshing writing style engenders a true engagement and intimacy among the reader, the author, and the content. Good historic context is established to ground the reader's understanding of the calamity of the contemporary issues we now face, as well as the anemic promise of Evidence-Based Practices (EBPs) in children's mental health service research.

Again, I am not surprised, as I have long known and episodically collaborated with John Lyons, and have always found his work to serve as a lightening rod of systemic change. To paraphrase Walker Percy, I see John as being northwestern smart and southern shrewd. Just read his wonderfully fun and heuristic characterizations of syndromes as examples attesting to this point.

Beneath the author's tousled, low-key approach is a boiling drive to take on the lumpen pip-squeaks, the zealots, the copycats, and the walk-ins. Lyons is a Roman candle of child welfare enthusiasm, unafraid to push back on the gravitational center of popular opinion or currently touted therapy du jour. His approach is to latch onto that occasional shivering truth that flies centrifugally out of its insular, centripetal whirl, and build on contemporary realities with science and psychological horsepower so that ignorance and the sacred cows fall in a hail of pedantry.

It is rare indeed to read in one book of Nobel laureates in economics, Kuhn, child welfare, mental health, family, stigma, racism, management theory, psychopharmacology, DRGs, Individual Education Programs, community, faith, and poverty—to just name a few of what may have previously seemed to be divergent topics, finely articulated thanks to John Lyons's expert weaving of them into the beautiful tapestry that is this volume.

This work has the potential to unleash a Niagra of new work, if not improved thought for avoiding the traditional Pyrrhic victories so common in this field. This body of work indicates that the future of improving children's mental health systems of care is already here, it's just not evenly distributed. In this book, Lyons says it best in that it is incumbent upon us to "evolve an effective system of care for children." This book gives readers the tools to do so. I encourage you to get started reading.

Chris E. Stout
Series Editor
Contemporary Psychology

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Acknowledgments

There are an enormous number of people who have contributed either directly or indirectly to the experiences contained in these pages. I am sure that I cannot thank everyone whose efforts are reflected in this work, but I will try. I am particularly grateful to Harry Shallcross, who introduced me to working with the children's public system and whose wisdom and vision is reflected in my experiences. Also, I am indebted to Ken Howard, who was a mentor and colleague and inspired my interests in outcomes management approaches. Melanie Lyons has been instrumental in the success of the Child and Adolescent Needs and Strengths (CANS) through her work with the Buddin Praed Foundation, for which I am very grateful.

Purva Rawal and Annie Engberg were exceeding helpful in the preparation of this book, as were Justin Burnholdt, Inger Burnett-Ziegler, Julie Eisengart, Crystal Jackson, and Elyse Hart. I do not know how I would have finished it without them.

I have had the pleasure of working with a number of people in the child service system whom have shared their experiences in ways that influenced my thinking. Among these people, I am particularly grateful to Connie Almedia, Barbara Anderson, Sheila Bell, Brita Bishop, Lise Bisnaire, Dianne Borgesson, Bill Bouska, Julie Caliwan, Allison Campbell, Sharon Carpinello, Kathleen Cassidy, Pat Chesler, Jon Collins, Bill Conlin, Mary Jane England, Marcia Fazio, Chip Felton, Tom Finegan, Susan Furrer, Tim Gaeworin, Joe

Gordon, Stephanie Greenham, Gene Griffin, Grant Grissom, Stacey Hirsch, Ardas Khalsa, Michael Lee, Joe Loftus, Joan Mechlin, Wanda Miles, Peter Neirman, Angelica Oberlightner, Celeste Putman-Tanzy, Candace Putter, Mary Beth Rauktis, Laura Rogers, Linda Rosenberg, Sue Ross, Patricia Tennant Sokol, Ann Stanley, Linda Touche-Manley, Peter Tracy, Gwen White, and Michael Zuber.

Over the past decade, my academic colleagues have had an enormous impact on my thinking. Much thanks to Rachel Anderson, Mary Armstrong, Peter Budetti, Rowland "Bing" Chang, Robert Cohen, Judith Cook, Peter de Jonge, Norin Dollard, Mina Dulcan, Dorothy Dunlop, Elizabeth Durkin, Jane Holl, Frits Huyse, John Lavigne, Tony LoSasso, Zoran Martinovich, Michael O'Mahoney, Frank Reyes, Joris Slaets, and Peter Zeldow.

Many of my students, fellows, and staff over the past decade have all contributed to this effort. I would like to thank Melissa Abraham, Dana Baerger, Julia Cathcart, Nina Christopher, Kya Fawley, Jena Helgerson, Michael Jenuwine, Renanah Kaufman-Lehner, Cassandra Kisiel, Scott Leon, Dan Marson, Adam Naj, Farah Quadri, Michael Scherer, Matthew Shaw, Courtney West, and many others for their help.

And finally, I would like to acknowledge my children, Trevor and Caitlin, and my stepdaughters, Cassie and Hillary, from whom I have learned most of what I think I know about growing up.

CHAPTER 1

The History of Children's Public Mental Health Services

The modern history of efforts to address the needs of children can be dated to the Renaissance and the beginnings of the industrial revolution. As cities became larger and the population center of gravity shifted from farms, the problems of children became apparent and a variety of strategies were introduced, initially to contain them and eventually to help them. One of the first approaches tried was to open penal institutions to house children whose behavior had become a burden to society. The first penal institutions for children were developed in 1695 in Halle, Germany, by August Francke and in 1704 by Pope Clement in Rome. Around the same time, orphanages were organized by religious and charitable organizations to serve abandoned and homeless children in large cities. The "treatment" component of these institutions could be described as "moral" in that religious training was a common focus of daytime activities. The first orphanage in the United States was opened by the nuns of the Ursuline Convent in New Orleans in 1745.

Over time, the number and size of these orphanages grew and the philosophies regarding the use of daytime activities began to evolve. In the early nineteenth century, the case of the Wild Boy of Aveyron sparked the introduction of the concept of "milieu therapy." This was the case of a boy who was captured by villagers in rural France. The boy was dirty, moved on all fours, and grunted like a beast. Despite a grim prognosis from the imminent Philippe Pinel and a period of

exhibition in a cage, a young physician, Jean Marc Gaspard Itard, took the boy in and over a period of years taught him to read and obey simple commands.

From this case—both the wild origins of the boy and the effects of his education—the notion of the potentially therapeutic effects of the environment were recognized. Milieu therapy is a treatment approach that seeks to foster a therapeutic environment by facilitating the natural interaction of persons with similar or like conditions. In applying this approach, groups of troubled children were brought together so that therapeutic approaches could be applied to all the children as they interact with each other.

Milieu treatment was a powerful force in the early children's mental health system, because it provided a justification for institutionalizing children. What better way to form a milieu than to create long-term placements for children so they could interact among themselves over an extended period of time. Thus, milieu therapy—although at the time seen as a humanistic breakthrough in the treatment of all persons with mental illness, including children—supported the creation of large institutional structures for the children's treatment system. Milieu therapy was just the first example of a theory of treatment supporting the popular approach at that time—in this case the removal of problem children from society. We now understand that the unintended consequence of milieu therapy was that the basic model of care required that children with mental health problems were identified and attempts were made to put them together with other children with mental health problems.

Despite the utility and efficiency of milieu therapy, as it turns out, it might not have been a particularly good idea. As Peter Senge (1990) notes in his book, *The Fifth Discipline: The Art and Practice of the Learning Organization*, most of today's problems are yesterday's solutions. Dishion, Bullock, and Granic (2002) have recently provided a careful integration of existing research findings from randomized clinical trials to demonstrate a contagion effect in group treatments of high-need youth, particularly those involved in delinquency and/or substance abuse. In other words, aggregating youth with serious problems into a milieu may have disturbing iatrogenic effects of making these youth's problems worse.

In addition to stimulating the creation of milieu therapy, the Wild Boy case also may represent the first time notable public attention was turned toward the idea that troubled children could be helped. Stigma against mental illness is probably as old as civilization;

however, in the past century we have appeared to make progress in reducing the unfairly negative views. In this regard, the Wild Boy of Aveyron might represent a critical event in beginning to turn public opinion toward a less stigmatizing view of mental illness.

Throughout the nineteenth century, institutions that served children continued to evolve. Innovation in children's services began to come more rapidly, as shown in the timeline in Table 1.1. Perhaps the most striking development was a differentiation of the developing child-serving system. At the start of this century there were no distinctions made based on different needs. Children with problems of delinquency, mental illness, or development disabilities were all served at the same institutions. However, during the century, attempts to create different milieus for children with different needs were initiated.

Table 1.1
A Timeline for the History of Children's Mental Health Services in the United States

1824	Society for the Prevention of Pauperism became the Society for the Prevention of Delinquency
1840s	Dorthea Dix began her work founding psychiatric hospitals
1860	Eugenics movement began
1880	National Association for the Protection of the Insane and Prevention of Insanity was formed
1883	G. Stanley Hall published *The Contents of Children's Minds*
1887	Hermann Ebbinghaus published the first systematic view of psychiatry
1890s	John Hopkins began to open institutions for children
1896	Lightner Witmer opened the first clinic for children at the University of Pennsylvania
1899	First juvenile court established in Cook County, Illinois
1905	Freud published *Three Contributions to the Theory of Sex*, which established a conceptual basis for child psychiatry
1908	Clifford Beers published *A Mind that Found Itself*
1909	The first White House Conference on the Care of Dependent Children was held in Washington, D.C.
1910	William Healy established the Psychopathic Institute for Children in Chicago, Illinois
1912	National Committee for Mental Hygiene made mental health a public health issue

1918	New York State Hospital Commission recommended the elimination of poverty as a preventive measure against mental illness
1920	The Child Guidance Movement began
1921	The Monmouth County Demonstration was initiated as the first experimental project of the National Committee for Mental Hygiene on the prevention of delinquency
1922	The National Committee for Mental Hygiene began waging a campaign for the creation of children's clinics
1930	The First International Mental Hygiene Congress was held in Washington, D.C.
1942	Leo Kanner published the first text on child psychiatry in English
1944	Bruno Bettleheim integrated psychoanalytic treatment with milieu therapy at the Orthogenic School
1946	The National Mental Health Act was passed
1947	The World Federation for Mental Health was established
1949	The National Institute of Mental Health was established
1951	John Bowlby published "Maternal Care and Mental Health" in the *Bulletin of the World Health Organization*
1955	The Mental Health Study Act was signed
1963	The Community Mental Health Act was signed
1965	Joint Commission on the Mental Health of Children was established
1974	Public Law 94-142 was passed, which mandated that children with disabilities, including behavioral and emotional disorders, be treated in the least restrictive environment
1975	Passage of the Individuals with Disabilities Act, which established special education rights for school children with emotional and behavioral problems
1978	The President's Commission on Mental Health, Task Force on Infants, Children, and Adolescents issued its report
1980	The Willie M. class action suit was filed
1982	Judith Knitzer published *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services* (1982)
1984	The National Institute of Mental Health initiated the Child and Adolescent Service System Program
1989	The Federation of Families for Children's Mental Health was formed

1996	Costello et al. (1996) published the first community-based epidemiological study of psychiatric disorders in childhood
1999	David Satcher, M.D., released the U.S. Surgeon General's report on mental health
2001	David Satcher, M.D., released the U.S. Surgeon General's report on the Conference on Children's Mental Health
2003	President's New Freedom Commission on Mental Health released its final report

Late in the nineteenth century, the concept of treatment of mental health problems began to evolve. Sigmund Freud is generally credited with the innovation of talking therapies (although in his case, it involved mostly listening). His psychoanalytic treatment was designed initially to treat hysteria, a disorder thought to be relatively common among women at that time. Most of Freud's early patients were wealthy European women. Although the focus of Freud's treatment innovations was on adults, his theory of the development of psychopathology emphasized childhood experiences and developmental stages.

In the United States, the current public mental health system for children received its formal start with the Mental Hygiene Movement of the nineteenth century, which is credited with the creation of our modern concepts of mental health and illness and the origins of a compassionate care system. One component of the movement was the belief that mental illness arose from painful childhood experiences. This causal assumption naturally created interest in understanding the development of psychiatric problems among children. That is, childhood would be the time in which mental illness would first start to manifest itself. Although prevention was not yet a common concept, the value of initiating treatment at the earliest possible time was a commonly held belief. Thus, it was believed that if you could detect mental illness in children, the best time to initiate treatment would be in childhood.

A primary locus of all mental health services during the nineteenth century was the psychiatric hospital. In the early parts of this century, when children were hospitalized, they were placed with adults. This began to change during the 1820s. Around this time, society was beginning to recognize the differences between children and adults that suggested different intervention strategies might be necessary. For example, in 1824, the Society of the Prevention of Pauperism

became the Society for the Prevention of Delinquency. This group encouraged the initial steps of separating children who broke the law from adult criminals. The society supported the proposition that children were easier to correct and heal than were adults and that this correction should involve training, not punishment.

About this time, the first efforts to address the mental health needs of youth involved with the criminal justice system were established. In 1909, William Healy, a neurologist, established the Juvenile Psychopathic Institute in order to advise the courts on the psychology of youthful offenders. However, even at the turn of the century, the focus remained on conceptualizing behavioral health problems within a moral framework. For example, hyperactivity was conceptualized as a defect in moral judgment well into the 1900s.

During this period, institutions were the primary locus of treatment. Admission standards to these hospitals were rather vague; there were few legal restrictions placed on decisions to admit a person. Thus, most power in the system was placed with the admitting physician.

Beginning in the middle of the twentieth century, the nature of treatment of children, particularly those in institutional settings, began to change. "Child Psychiatry" was first defined as a distinct focus within psychiatry in the 1930s, although it did not really expand until after World War II. This led to recognition of the need for, and development of, specialized knowledge about children's mental health.

In the most comprehensive initial example of a child-specific treatment approach, Bruno Bettleheim, who became the Director of the Orthogenic School at the University of Chicago in 1944, is credited with combining milieu therapy approaches with psychoanalytic treatment. This innovation represents the first generation of what is now referred to as residential treatment for children. Having experienced the profound effects of Nazi concentration camps on changing personality for the worse, Bettleheim became convinced that one's environment also could change personality for the better. Sadly, his understanding of psychoanalytic theory led him to place a significant amount of blame for children's behavioral problems on their parents, particularly mothers. It was standard practice at the Orthogenic School to forbid parental visits for the first six months of treatment because it was thought to be "countertherapeutic." This theory of the pathogenic nature of parenting, shared by many theorists in the mid-twentieth century, was the origin of the tensions that are still

manifest in the system between clinicians and parents of children with serious emotional or behavioral problems.

In the early 1960s, a set of factors worked together to create the Community Mental Health Movement. These factors included an aging and expensive state hospital infrastructure, breakthroughs in psychopharmacology, and recognition of the civil rights of persons with mental illness. Initially, this movement was characterized by deinstitutionalization, which primarily involved adults with severe mental illness. Deinstitutionalization describes the process of relocating long-term residents of state psychiatric hospitals into community settings. However, the formation of community mental health centers (CMHCs) has had a lasting impact on the children's system as well. Within the CMHCs created by the Community Mental Health Acts of 1963 and 1965, each CMHC was developed to serve a specific geographic area, known as a catchment area. (Note: For linguistic buffs the term "catchment area" resulted from the initial use of the sewer maps to define geographical areas. Catchment basins are used to collect sewage within certain geographies. The translation of this term to public mental health only reinforces our field's problems with stigma.) In many areas, CMHCs became the primary community agencies providing outpatient mental health services to children and families.

In 1969, the United States federal government officially recognized the inability of the mental health service system to meet the needs of children through a report issued by the Joint Commission on the Mental Health of Children (1969). One of their major findings was that children often were involved with multiple child-serving agencies simultaneously. The overlap among children served by public mental health, child welfare, juvenile justice, and special education was enormous. This overlap represented both an opportunity and a challenge that continues today. Historically, different child-serving agencies tend to function in a vertical organization within the agency. Thus, child welfare would create an entire system of care for the wards of the state. Juvenile justice would create a different system. Child-serving agencies in this organization structure have been referred to as silos because they are self-contained and there is little opportunity for cross-agency collaborations.

In 1974, United States Public Law 94-142 was passed, which mandated that children with disabilities, including behavioral and emotional problems, receive education in the least restrictive environment. The concept that it is a civil right to have the most personal

liberty possible given one's clinical needs is one of the foundational principles of the system of care philosophy.

Although the 1960s and 1970s witnessed the creation of a number of committees and task forces that assembled and reported, it was not until 1982 when Judith Knitzer published her classic book *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services* (1982) that the next stage of evolution occurred in the children's mental health service system. Funded by the Children's Defense Fund, Knitzer combined multiple data sources from all 50 states and focused on three million children with serious emotional disturbances. She found that the majority were either not receiving services or were receiving inappropriate care. Knitzer specifically cited the lack of a federal role in the children's service system. She observed that there was little funding provided, and for what was provided there was little or no follow-through to ensure effective applications of scarce dollars. Knitzer's book led to the renewed interest in children's services and activated a coalition of advocates. In many ways, the development of the current system of care was a direct result of this book.

In 1975, Congress first passed the Individuals with Disabilities Act (IDEA), which mandated special educational opportunities for children with disabilities, including behavioral health problems. This legislation was reauthorized in 1990. IDEA established special education services for children with emotional and behavioral problems. Although IDEA represents an important breakthrough for attending to the unique educational needs of these children, it is largely an unfunded mandate because most school funding comes from local districts. Because the majority of children in special education are poor minorities, they tend to reside in poorly funded school districts (American Institute for Research, 1994).

Although the epidemiology of psychiatric disorders had been studied by the National Institute of Mental Health in the late 1970s and early 1980s (Reiger & Burke, 1987), the extent of mental health problems among children was unknown. This changed in 1996 when Costello et al. published the first community-based study of the epidemiology of psychiatric disorders in childhood. These researchers reported that 25 percent of children had at least one moderate psychiatric disorder and that 5 percent had severe emotional/behavioral disorders marked by significant impairments in functioning. Only one in five children with a diagnosable psychiatric disorder received any specialty behavioral health services. These data clearly established

that psychiatric disorders were common among children and adolescents and that the existing service system failed to address many of these children's needs.

System-of-Care Philosophy

Partially in response to Knitzer's work, a group of children service system experts began to reconceptualize what the children's service system should look like in order to better approximate an ideal system. From this work the concept of a system of care has arisen. Stroul and Friedman (1986) are credited with first laying out a system-of-care philosophy to design and implement comprehensive and effective services for children. The philosophy is expressed through a set of care values and guiding principles that can be found in Table 1.2. Essentially, the overarching goals are to keep children at home, in school, and out of trouble (Rosenblatt, 1993). These outcomes and goals come from a belief that the best place to raise a child is with their family living in the community.

Table 1.2
Core Values and Guiding Principles of the Child and Adolescent Support Services Programs (CASSP)

CASSP Core Values

1. The system of care should be child centered, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.

CASSP Guiding Principles

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.
3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.
5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Emotionally disturbed children should be ensured smooth transitions to the adult services system as they reach maturity.
9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

Source: Adapted from the Child and Adolescent Support Services Programs guidelines (Stroul, 1993).

A key approach that arises out of the system-of-care philosophy is enhancing the degree to which the partners in a system collaborate to achieve shared goals. As programs and services grow in size, scope, and specialization, the organization and management of these programs and services become more difficult. For instance, it used to be that you could go to your family physician for most medical care. Now, with most insurance plans, you have to go to a primary care doctor to get permission to go to a specialist. In the children's system, a parent might take their child one place for medication management and another place for therapy, all while the child is in a day-treatment program funded through the school system. Although each program might function in the best interests of the children and families it serves, the resultant inefficiency in the overall system can result in less-than-optimal outcomes. For this reason, system-of-care

philosophy has emphasized local control and management of service system. Multiple, centralized bureaucracies can be less responsive to individuals and less flexible in addressing different needs with different strategies. Large bureaucracies have a tendency to continually develop polices and procedures (they employ people whose primary job it is to develop these documents). The ever-evolving policies and procedures with their inevitable paperwork serve to make service receipt increasingly complex in these circumstances. When a parent is forced to deal with multiple bureaucracies (e.g., school, court, and child welfare) at the same time, significant barriers to an integrated approach to services are natural by-products.

Among the most important work in the development of systems of care has been the establishment of programs initially funded by the Robert Woods Johnson Foundation (RWJ). These projects were intended to nurture the development of local systems of care for children and families based on the principles laid out by Stroul and Friedman (1986) for the Child and Adolescent Support Services Programs (CASSP). The intervention strategy was the wrap-around process (Burchard, Burchard, Sewell, & VanDenBerg, 1993; VanDenBerg & Grealish, 1998). Following the experiences with the RWJ-funded sites, the federal government became involved in the process through the Center for Mental Health Services of the Substance Abuse Mental Health Services Administration (SAMHSA). SAMHSA has funded more than 100 system-of-care demonstration sites over the past decade. For children and adolescents with mental health challenges, the CASSP principles have become the foundation for system-of-care initiatives around the country. Few would argue with the proposition that services for children and families should be designed with these principles in mind.

In 1999, the United States Surgeon General, David Satcher, M.D., published the first Surgeon General's report on mental health (U.S. Surgeon General, 1999). This groundbreaking document may well be one of the first times an independent health care entity recognized and endorsed the effectiveness of existing behavioral health services. The report points to a number of significant events over the prior decade, including the breakthroughs in our understanding of brain–behavior relationships, the introduction of a wide range of new treatments, the transformation of how behavioral health services are organized and financed, and the emergence of powerful consumer and family movements. This report identified eight goals related to children's mental health that can be found in Table 1.3.

Table 1.3
Goals of the U.S. Surgeon General's 1999 Report on Mental Health

1. Promote public awareness of children's mental health issues and reduce stigma associated with mental illness.
2. Continue to develop, disseminate, and implement scientifically proven prevention and treatment services in the field of children's mental health.
3. Improve the assessment and recognition of mental health needs in children.
4. Eliminate racial/ethnic and socioeconomic disparities in access to mental health care.
5. Improve the infrastructure for children's mental health services, including support for scientifically proven interventions across professions.
6. Increase access to and coordination of quality mental health care services.
7. Train frontline providers to recognize and manage mental health issues, and educate mental health providers in scientifically proven prevention and treatment services.
8. Monitor the access to and coordination of quality mental health care services.

Source: Adapted from U.S. Surgeon General. (1999). *Mental health: A report to the Surgeon General.* Washington, D.C.: Department of Health and Human Services.

In 2001, Dr. Satcher published the results from a conference on children's mental health (U.S. Surgeon General, 2001b). His report set out a vision and specific goals for the U.S. children's mental health service system. The vision had four guiding principles:

1. Promoting the recognition of mental health as an essential part of children's health.
2. Integrating family-, child-, and youth-centered mental health services into all systems that serve children and youth.
3. Engaging families and incorporating the perspectives of children and youth in the development of all mental health care planning.
4. Developing and enhancing a public-private health infrastructure to support these efforts to the fullest extent possible.

The conference members then outlined the following eight goals:

1. Promote public awareness of children's mental health issues and reduce stigma associated with mental illness.
2. Continue to develop, disseminate, and implement scientifically proven prevention and treatment services in the field of children's mental health.
3. Improve the assessment of and recognition of mental health needs in children.
4. Eliminate racial/ethnic and socioeconomic disparities in access to mental health care services.
5. Improve the infrastructure for children's mental health services, including support for scientifically proven interventions across professions.
6. Increase access to and coordination of quality mental health care services.
7. Train frontline providers to recognize and manage mental health issues, and educate mental health care providers about scientifically proven prevention and treatment services.
8. Monitor the access to and coordination of quality mental health care services.

Also in 2001, the U.S. Surgeon General's office (2001a) came out with a supplemental report on race, culture, and ethnicity. In this report, the research demonstrated a significant and disproportionate burden of unmet mental health needs among minority populations. Addressing these racial disparities in service receipt was identified as a national priority.

In early 2001, President George W. Bush announced the formation of his New Freedom Initiative, which was intended to promote increased access to employment and educational opportunities for persons with disabilities. The initiative also had the stated mission of improving access to full community life and to assistive and universal technologies that promote health, well-being, and full access. The vision of the New Freedom Commission on Mental Health (2003, p. 1) was stated as follows:

> We envision a future when everyone with mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully in the community.

Three primary barriers were identified that prevent persons with mental health challenges from obtaining the excellent services they need and deserve:

1. The stigma of mental illness.
2. Unfair treatment limitations and financial restrictions placed on mental health benefits in private insurance.
3. A fragmented mental health service system (New Freedom Commission on Mental Health, 2003).

Thus, both the New Freedom Commission and the previous U.S. Surgeon General agree that standing in the way of progress toward an accessible and effective system of care for children and adolescents are attitudes about mental health, financing strategies with unintended consequences on the quality of care, and a lack of cohesion in the organization and functioning of service components. Success requires overcoming these barriers.

The Current State of System Components

Consistent with the New Freedom Commissions identification of barriers and despite the focus on developing systems-of-care philosophy in the children's public mental health system, in most places the system primarily consists of its component parts and thus is a system in name only. As such, it is useful to review the current status of these public mental health system service components.

Wraparound Process

Although not a formal component in the system of care, the wraparound process has been identified as a critical strategy for developing systems of care through the creative use of existing services and natural supports. Essentially, wraparound refers to a planning process that results in an individualized and, therefore, unique array of community services and natural supports that are selected in a team process directed by the child and family. The focus is on strengths, with attention to flexibility, cultural relevance, and coordination across system partners (Burchard, Bruns, & Burchard, 2002).

The ten principles of the wraparound can be found in Table 1.4. Taken from Goldman and Faw (1999), these principles essentially build a bridge between the CASSP principles and the service planning or case management process. They represent an important link