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Advancing Efforts to Improve Children's Mental Health in America: A Commentary

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Childhood emotional and behavioral disorders are the most prevalent and costly of all chronic illnesses in youth. In 2006, 8.9 billion dollars was spent for the treatment of mental disorders in children which was highest of any children's health care expenditures exceeding asthma, trauma-related disorders, acute bronchitis, and infectious disease (Soni 2009). It is estimated that 20% of children and adolescents have a diagnosable mental, emotional, or behavioral disorder and this costs the public $247 billion annually (National Research Council and Institutes of Medicine et al. 2009). Of children and youth in need of mental health services, 75–80% of these youth do not receive services (Kataoka et al. 2002). It is also estimated that of the 2 million youth aged 12–17 in 2007 that met criteria for a major depressive episode, only 39% actually received services (SAMHSA/OAS 2009). Given the estimated prevalence of emotional and behavioral disorders, the limited access to appropriate services and the costs associated with these conditions it is critical that we continue to develop efficient and effective strategies for addressing this public health crisis (Alegria et al. 2010; Stelk and Slaton under 2010).

This issue of *Administration and Policy in Mental Health and Mental Health Services Research* dedicated to children's mental health provides an important forum for examining where we are in children's mental health and where we need to go. The papers represent an important dialogue and a rich exchange of ideas and perspectives from the September 2009 Conference entitled, Child and Adolescent Mental Health Services: Issues and Solutions. We are pleased the have the opportunity to comment on these discussions.

The Children's Mental Health Initiative, legislated by the US Congress and implemented by the Substance Abuse and Mental Health Services Administration (SAMHSA), has been the major funded effort in the field of children's mental health services for the past 17 years. Building on the systems of care principles and philosophy (Stroul and Friedman 1986) what started as a small demonstration program in 1993 has now become a $120 million program in 2010. Since its inception, this CMHI has served 164 Communities in all states, multiple tribes, territories, and jurisdictions. Over 100,000 children have received direct services through a system of care approach. An increasingly sophisticated and systematic evaluation of this program shows important outcomes in terms of functional status and quality of living for the children and families engaged in the system of care approach.

Data collected as part of the national evaluation of systems of care indicates improved emotional and behavioral functioning, reductions in the use of inpatient and juvenile justice facilities, and improvements in school attendance and performance (Manteuffel et al. 2008). More specifically, 2008 data showed that emotional and behavioral problems were reduced significantly or remained stable for 93 percent of children and youth 24 months after entering services, child/youth suicide attempts were reduced by one third within 6 months after entering systems of care, and further reduced by over two thirds after 24 months, regular school attendance (i.e., 80 percent of the time or more) increased from 82 percent at intake to nearly 90 percent after 24 months in systems of care, and the percentage of children and youth suspended or expelled

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decreased from 48 percent at intake to 32 percent at 24 months. Additionally, the average arrests per youth dropped from 0.33 at intake to 0.18 at 24 months resulting in a cost savings of nearly $622 per youth in the SOC program. There was also a significant cost savings in inpatient care, as children require fewer days in these facilities once in a system of care program. Because there were no comparison groups included in the national evaluation, additional research will be important to further validate the causal nature of these findings.

This system of care effort has done well, but can do better. It is critical that the system of care initiative stays connected to emerging developments in the field of children's mental health. In accord with the papers in this issue, we offer comments on five general themes: integrating systems of care with a public health approach, implementing evidence-based practices systematically and reasonably, developing productive linkages between researchers and practitioners, building in measurement strategies to support and guide practice change, and deepening the operationalization of family and youth-driven care. Each of these will be discussed below.

Public Health Approach

A public health framework is a new and evolving context for systems of care that is clearly articulated throughout the papers (Stiffman et al. 2010). There are multiple definitions and frameworks for a public health approach. Clarity and consensus is needed here on how to translate this into federal policy and how to pay for this approach. Recently, with support from SAMHSA's Child Adolescent and Family branch, Georgetown University's Center for Child and Human Development convened key thought leaders and developed a monograph entitled "A Public Health Approach to Children's Mental Health: A Conceptual Framework" (Miles et al. 2010). This calls for a paradigm shift moving from the idea that any one system is responsible for children's mental health. Rather, multiple partners, disciplines, and sectors that touch children's lives must come together to advance the health of America's children. This requires a partnership between education, early child care providers, juvenile justice, recreation programs, faith-based organizations, etc. to examine their role in children's mental health.

This re-conceptualization of children's mental health within a public health framework is strengths-based and calls for taking a population focus, incorporating both promotion (supporting optimal health) and prevention (addressing problems before they occur), and understanding the determinants of health (factors that contribute to good and bad health outcomes). In addition, a new term, "Reclaiming" is used to reflect interventions and actions that optimize positive mental health for children and youth with identified mental health problems. Reclaiming is broader than the concept of "recovery," and emphasizes the holistic striving for optimal health rather than just alleviating the suffering associated with mental illness.

An increase in access to services and improvement in quality may be necessary but are not sufficient to significantly improve the mental health status of children in this country. Prevention practices are essential as mental health treatment is often too late and too little. In addition, a large number of health outcomes can be attributed to social/behavioral factors, to the environment, to socioeconomic factors, to genetics, and to the health care delivery itself (National Research Council and Institutes of Medicine et al. 2009). Thus, health care is not the sole determinant of health or arguably even a major one and a paradigm shift should be made towards prevention and the identification of factors that put children at risk for emotional and behavioral disorders.

How can we begin to expand the traditional perspectives of diagnosis and individualized treatment to a broader, population-focused approach that seeks to promote positive mental health for all children and youth, ameliorate risk factors, and prevent the onset of illness, and identify and address problems early in their development? The challenge is to design a system of care inclusive of these components where there is a balance between taking care of the needs of children and youth with serious mental health challenges and seeking to avoid these conditions in the first place.

Implementing Evidence Based Practice

The article "Critically Examining the 'Status Quo' in Children's Mental Health Care" (Garland et al. 2010) calls for a deeper understanding of the children's mental health system in order to properly tailor interventions and understand "what works." The system of care philosophy is to specifically target treatment towards what is needed in the community. Care is individualized and community-based while the system of care principles and values remain constant, what is actually built in terms of an infrastructure and services for children will be community-specific.

Many important interventions were developed by creative practitioners in the field and have since been shown to be efficacious. An example of this in children's mental health is the development of wraparound services (Suter and Bruns 2009). Data from the field have suggested that this is an effective intervention; however, standardization of this treatment and randomized controlled trials are relatively new after nearly 20 years of work in the field (Holden and Blau 2006).

Accountability must be a shared responsibility and that the system will benefit from assistance across many constituency groups. From universities we need to improve curriculum and training programs so that clinicians and practitioners learn how to collect and incorporate data into practice, and how to analyze those data to improve performance and outcomes. From practitioners we need to understand evidence based practices and implement the components and ingredients that are related to effective practice. From researchers we need to seek independent funds to conduct more methodologically sophisticated studies so that we can compare the effectiveness of various interventions, especially those that are delivered in "real world" settings. From youth and families we need to become better educated in order to ask the right questions of providers and system leaders about service approaches and effectiveness. And, from administrators and policy makers we need to provide the support and resources necessary to accomplish the goals articulated in the articles of this special edition.

Linkages Between Researchers and Other Groups

We acknowledge the recommendations to build better linkages between the research community and systems groups. The Systems of Care concept is premised on partnerships and linkages, thus improving partnerships between researchers, mental health workers, and consumers will no doubt improve system functioning. It should also be noted that there have been evaluators and applied researchers integrally involved with SOC development and evaluation. Additionally, family members are not only participants in the research but participate as researchers. Thus, they are involved in forming the research questions, data collection, and analysis. This is aligned with the family driven principle of SOC and is done to engage community members in research activities and assist in data use and dissemination for local purposes. This has evolved into spin-off studies with NIMH researchers and evaluators involving families (e.g., Olin et al. 2009).

SAMHSA is open to formal and informal linkages and partnerships. Aware of the need to link researchers and community members and the importance of the community participatory research model, SAMHSA participated in the joint, interagency grant announcement, " Recovery Act Limited Competition: Building Sustainable Community-Linked Infrastructure to Enable Health Science Research (National Institutes of Health 2009)" with the purpose to develop relationships between researchers and the communities. The mandate here is community-researcher partnerships. This moves beyond building community partnerships as a means for participant recruitment; here the partnership is designed to enhance the quality, relevance and applicability of the research and dissemination of findings. Portions of the SOC national evaluation are also designed with this model in mind. Members of the community conduct a portion of the evaluation to connect the researchers with the community and enhance data dissemination and usage.

Measurement and Practice Change

Data feedback systems such as the ones proposed by Bickman (2008) and Chorpita et al. (2008) are important in incorporating evidenced informed practice. These systems are a possible direction to improve the quality of care and enhance clinical practice within systems of care. This could be a promising next step but it is first critical to see what is feasible in the field.

Program evaluation and continuous quality improvement (CQI) have been central to the development of the systems of care infrastructure (Sheehan et al. 2008). A CQI Progress Report and Benchmarking Initiative for CMHI was instituted in 2004 by the Child, Adolescent, and Family Branch of SAMHSA. This system is designed to target technical assistance to the grantees to ultimately improve the services given to children and their families. Consistent with the previous section on building bridges between researchers and communities is the mandate that CQI efforts in SOC must involve stakeholders such as families and youth being served.

Family-Driven and Youth-Guided Care

One critical arena that we would have preferred to receive more attention in the special issue involves the importance of developing a family-driven and youth-guided approach. It was mentioned in several of the articles (e.g., "Toward the Integration of Mental Health and Education in Schools (Atkins et al. 2010);" "One Size Does Not Fit All: Taking Diversity, Culture and Context Seriously;" "Workforce Development and the Organization of Work;" "The Role of Infrastructure in the Transformation of a Child-Adolescent Mental Health System;" "Organizational Capacity to Deliver Effective Prevention and Treatment Services for Children and Adolescents (Kelleher and Atkins 2010);" and " Improving the Linkage between Research and System Change: Making it Real (Stroul et al. 2010)"); however, given the growing importance of family to family services (Hoagwood et al. 2009), we believe more concentrated attention would have been warranted. In fact, in the publication of the New Freedom Commission Report (SAMHSA 2003) the field was charged with the

next step, which was to become family-driven. Since that time, much has been written about what it means to be family-driven and a set of guidelines and operating principles have been established (Osher et al. 2008).

More recently, the young people themselves are being empowered to take on more decision making with respect to their own treatment and the system planning efforts (Matearese et al. 2008). As part of the SOC effort, a national organization was developed, called Youth MOVE National, Inc (Youth Motivating Others through Voices of Experience), which has become an important voice for youth who have had experience in multiple child-serving systems. Currently, Youth M.O.V.E. has chapters in eleven states across the nation.

In both of these endeavors the anecdotal information and preliminary data suggests that having families and youth as part of service and system planning and decision making improves outcomes (Kemp et al. 2009). More research is needed to document the effectiveness of this approach and to make it an acceptable and reimbursable standard of care.

Summary

Despite the obvious challenges, significant progress has occurred in the past 25 years in the field of child, adolescent, and family mental health. The state-of-the-science continues to improve and the field of children's mental health has developed and implemented a service philosophy that respects and includes families and youth, embraces diversity, and seeks to incorporate data into decision making. Evaluation efforts continue to point us in new and needed directions. There is a call for a discussion on the next steps in the policy agenda and implementation. SOC is not a static program but is responsive to data trends, an evolving research and practice, and an emerging health care context. Recommendations on how to incorporate new technologies for feedback at individual, community, and organizational levels are welcome. We are likewise open to a discussion around how to best fund and develop a work force in a public health context.

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