

---

Chapter 7

**Treatment in Non-Mental-Health  
Systems, Prevention, and the  
Integration of Mental Health  
and Other Services**

# Treatment in Non-Mental-Health Systems, Prevention, and the Integration of Mental Health and Other Services

---

## INTRODUCTION

Mental health treatment, it is widely agreed, should take place in the context of a child's life. Children are uniquely dependent on their families, schools, and communities, and are continually affected by these influences. Disturbed children are more likely than other children to fail in school, to manifest a variety of medical problems, and to be involved with the criminal justice system. As a result, children's mental health problems are often first identified in settings such as schools, physicians' offices, and juvenile courts. These settings, along with others, provide important mental health treatment sources.

Understanding how treatment services are offered in non-mental-health contexts, such as the educational, health care, welfare, and juvenile jus-

tice systems, is essential for developing public policy. The interrelationship between mental health and other service systems provides opportunities to identify children in difficulty, to provide interventions at the site where mental health problems are identified, and to offer programs to prevent mental health problems. Currently, however, there is relatively little integration among mental health and other systems. This chapter considers needs for and provision of mental health services across various non-mental-health systems. It describes a number of programs and projects in the educational system, the health care system, the child welfare system, and the juvenile justice system, along with the development of integrated service systems.

## CHILDREN'S MENTAL HEALTH TREATMENT IN NON-MENTAL-HEALTH SYSTEMS

### Treatment in the Educational System

The importance of dealing with children's mental health problems in the educational system has long been recognized (see 602). Mental health problems interfere with a child's ability to learn and to manage in the social world of the school. Moreover, mental health problems are likely to have a great effect at school simply because of the number of hours that children spend there and the importance of education to their lives. Many children can receive an adequate education only if their mental health needs have been met.

Schools deal with the mental health needs of children in a variety of ways (157), but the potential of the educational system in meeting chil-

dren's mental health needs has not been fully realized. A tradition of referring children from schools to mental health treatment settings dates back to the child guidance clinics of the 1920s and 1930s. Some schools have their own mental health professionals, such as school psychologists and social workers, who provide mental health treatment within the school and provide consultation to other school staff (see 372). Other schools rely more heavily on external mental health professionals and a variety of referral resources. A subspecialty of education, special education, was specifically developed to serve the educational needs of children with learning disabilities and psychological and physical handicaps. Because of the difficulties involved in innovation in public schools

(407) and the difficulty of collaboration between the educational system and mental health system (437), mental health interventions in schools have not been widely implemented. Nevertheless, there has been substantial experimentation with such interventions. Experimental programs have provided extra classroom interventions for hyperactive children, learning-disordered children, conduct-disordered children, anxious (withdrawn) children, or heterogeneous groups of disturbed children. These experimental programs in schools have involved various therapeutic approaches. Behavioral interventions have been used extensively since the 1960s, and the use of cognitive interventions such as self-control and social skills training has been increasing. These interventions have been implemented by both teachers and mental health professionals.

The Education for All Handicapped Children Act (Public Law 94-142) requires that an education be provided to all physically and mentally handicapped children. For each handicapped child, the necessary educational and related services to enable the child to obtain an education must also be provided. The law requires the development of an individualized education program that specifies those educational and related services for each child. There has been some dispute over what a "related service" is and whether mental health treatments such as psychotherapy fall within that definition. There is a growing consensus that mental health treatments are related services, and this view has been supported by several court decisions (e.g., *Papacoda v. State of Connecticut*, 528 F. Supp. 68 [D. Conn. 1981], *In the matter of the "A" Family*, 602 P. 2d 157 [Mont. 1979]), cited in 358).

Who is to provide and who is to pay for educational and mental health services for disturbed children under Public Law 94-142 has been unclear. In some States, schools themselves offer psychological services, although school personnel providing such services often have less clinical training than out-of-school providers. When mental health services are provided in nonschool settings, it is often unclear whether the responsibility for payment rests with the schools or with



Photo credit: Very Special Arts

In general, mental health professionals believe that the least restrictive setting is most appropriate for treating children. Here, the educational system offers a valuable non-mental-health setting in which to treat children.

the parents. This is especially unclear when the necessary related service is a residential treatment. In 1984, 4 million students aged 3 to 21 received services under Public Law 94-142. The number of handicapped children receiving mental health services is not known.

The Federal contribution to activities mandated by Public Law 94-142 is relatively small: \$1.07 billion in fiscal year 1984, 25 percent of which was set aside for administrative and other support services, including "related health services" (657). Essentially, however, services for handicapped children are mandated, but resources are not provided to implement them. It is not known what portion of funds for psychological and mental health were spent for psychological services. A study to assess amounts spent by educational agencies on all related services, including psychological services, is due to be completed in fiscal year 1987 (656). The form that implementation of Public Law 94-142 should take is still being determined in a number of States, and responsibilities across education departments, mental health departments, and other service systems are still being considered.

## Treatment in the General Health Care System

Increasing evidence suggests that many children's mental health problems are seen by physicians in the course of delivering primary health care; but surveys differ on the extent to which office-based primary care physicians see and recognize mental health problems in children. In two recent surveys by Goldberg, et al., pediatricians reported that approximately 23 percent of the children they saw had a mental health problem (239, 240). Schurman and colleagues, using data from the National Ambulatory Medical Care Survey, found that about 11 percent of office visits to pediatricians and about 12 percent to family practitioners were by children with psychiatric disorders (588).

In Goldberg, et al.'s investigation, the majority of troubled children visited their physician's office because of a physical complaint, and their mental health problems were uncovered during the course of visits for other problems. Pediatricians often treated the mental health problems themselves, providing supportive counseling, practical advice or, less frequently, medication (239). Approximately 50 percent of the pediatricians in Goldberg, et al.'s samples (239,240) referred troubled children to a mental health professional,

Some observers are concerned about the level of mental health knowledge of many primary care physicians (239,240). Furthermore, although primary care physicians and mental health professionals may see child patients concurrently, their efforts are not always coordinated.

Two options open to many primary health care providers are obtaining mental health training (e.g., 85) and consulting with mental health specialists (543). The logic behind increasing the mental health skills of primary care providers is that they are likely to be the first professionals consulted regarding developmental and psychological problems of young children (504).

In addition to mental health consultation and mental health training for primary care providers, early intervention programs have been developed in primary medical care settings for children suffering from a number of childhood problems (536).

Prevention efforts have been used to help physically ill pediatric patients manage their illnesses without undue mental health consequences (323). Systematic mental health interventions in physical health care settings remain exceptional, however. Only in settings such as health maintenance organizations might mental health referrals and interventions be commonplace.

Evidence for the susceptibility of chronically ill and physically disabled children to mental health problems was noted in chapter 4. The prevalence of mental health problems seen by medical specialists in medical inpatient units is probably high.

## Treatment in the Child Welfare System

The child welfare system is involved with a substantial number of children who have serious problems. Child welfare systems intervene in cases of parental abuse and neglect and in other situations in which parental care is lacking (e. g., during a parent's illness).

### Treatment Needs for Children in Foster Care

A major form of intervention by child welfare authorities is foster placement. The child welfare system places an estimated **120,000** children per year in some form of foster care, usually within a home or institutional setting (48). There has been little research to ascertain what portion of this population enters foster placement with mental health needs.

Children generally enter the foster care system from family situations with problems including child maltreatment, parental psychopathology, and parental substance abuse—all of which are risk factors for mental health problems (see ch. 4). Only a small percentage of children have been placed in foster care because of their own behavior or disability (108). When placed in foster care, children suffer the trauma of separation from their original families (205). Many children who would be diagnosed as having psychological problems by mental health professionals are not recognized as having such problems by foster care placement agencies and staff (205). For the most part, these children are not placed in environments capable

of providing appropriate care for psychological problems (205).

Frank's study of treatment needs for children in foster care found that children involved in long-term foster care typically had severe psychosocial problems (205), both at the point of entry into foster care and 5 years later. Children who were rated at a level of medium to low functioning at entry into foster care slipped significantly to the lower level after the 5-year period. Frank found that 85 percent (composite percentage) of the sample of children in long-term foster care received inadequate treatment (apart from the quality of child care).

Several State studies suggest that the prevalence and severity of emotional disturbance is associated with the number of placements a child has experienced (108). Long-term and repetitive foster care placement, therefore, are likely to represent both sources and symptoms of problems for children with mental health needs. Yet child welfare agencies often have neither the money nor the experienced staff to provide mental health services, and coordination between welfare and mental health agencies is rare (358).

Alternatives to the usual pattern of foster placements are discussed below. These alternatives are therapeutic foster care, respite care, and care in group homes. Efforts to prevent the need for foster placement by enhancing parents' abilities to care for their children are discussed later in this chapter.

#### Therapeutic Foster Care

Mentally disturbed children who might otherwise be referred to psychiatric hospitals or residential treatment centers (RTCs) are sometimes placed in alternative family settings (83). Although separating a child from his or her parents is a significant intervention, therapeutic foster care is considered less intensive than treatment in a psychiatric hospital or RTC.

Well-run therapeutic foster care programs carefully select foster parents to take disturbed children into their homes for a finite period of time. These foster parents are generally expected to provide some therapeutic work and are typically paid more than other foster parents. Such parents, who

vary in their experience with mental health treatment, undergo training prior to therapeutic foster care placement. Professionals involved with foster care programs supervise and support the foster parents, arrange for other care needs of the disturbed children in foster care, and provide emergency professional care for foster children when needed.

The range of the intensiveness of treatment within therapeutic foster care programs is substantial, and the more intensive levels require more treatment-specific training, greater involvement of foster parents, and greater availability of adjunct services. In many States, different levels of therapeutic foster care are available to cover a range of impairment in children.

Children in therapeutic foster care usually receive mental health treatment beyond therapeutic foster care. The nature of this other treatment depends on the particular child's needs and the availability of local resources. Thus, for example, one child in therapeutic foster care may receive outpatient psychotherapy, while another may attend a day treatment program.

#### Respite Care

Respite care, a service related to foster care, involves placing children in homes with caring adults as an emergency intervention. Respite care provides children in need with a temporary protected environment. Such care may be necessary because of a crisis such as the emotional breakdown of parents or escalating conflict between children and other family members. Shelter from a crisis may be provided for several days or up to several weeks, until the child can return home or be placed in another appropriate setting.

#### Group Home Care

Group home care is similar to therapeutic foster care, except that a number of children (usually 10 to 12) are placed in a home at one time (709). Group homes are typically administered by social service agencies, which employ staff to live in the home or work there in shifts. Group homes usually have a somewhat more structured treatment program than therapeutic foster homes. Placement in group homes can last anywhere from

1 month to several years, and commonly includes concurrent treatment in a mental health setting.

### Treatment in the Juvenile Justice System

The juvenile justice system is a potentially major site for provision of mental health care to disturbed children and adolescents. By DSM-III criteria (see ch. 3), juvenile offenders with a history of behaviors such as fighting, stealing, lying, and running away from home would be diagnosed as having a conduct disorder. Often, however, the mental disorders of juvenile offenders are not formally diagnosed, and the number of juveniles who have mental disorders in addition to criminal or status offenses (offenses that are criminal only because the offender is a juvenile, e.g., truancy, running away from home) is not actually known.

The proportion of children and adolescents in the juvenile justice system who are regarded as mentally disordered or as having mental health problems obviously depends on what criteria are used to define mental disorders and mental health problems (601,723). Whether a child's problems are dealt with in the mental health system or in the juvenile justice system often appears to depend less on characteristics of the child than on how a particular behavior is defined (i.e., as a symptom or as a violation of the law) and on the system within a State or region for assigning service responsibility.

Coordinated interventions in which both the mental health and the juvenile justice system are

involved are rare (395). Mental health agencies are often reluctant or unable to take responsibility for intervention with juvenile offenders because of the danger and disruptiveness these children and adolescents present, and the juvenile justice system is often unable to treat the mental health problems of these youths. Many mentally disordered children have contact with both the mental health and juvenile justice systems, often moving back and forth between the systems. Frequently, children who are sent from one system to the other are those for whom original interventions have failed or been exhausted (395,723). The frequent and rapid transferring of these "turnstile" children (276) sometimes causes problems itself.

There are several models of coordinated mental health and juvenile justice interventions (601). A number of special mental health programs have organizational connections to State and county governments and provide comprehensive services to disturbed juvenile offenders (49,304,395,723). In some instances, States contract with private mental health agencies to provide services to children who come in contact with the juvenile justice system in specific geographic areas (395). Other programs provide mental health consultation directly to juvenile justice facilities (395,601). Case management (discussed below) has been used to resolve some of the problems of trying to serve disturbed children who are wards of the juvenile justice system, but the use of case management in the juvenile justice system is infrequent (49).

## PREVENTION OF CHILDREN'S MENTAL HEALTH PROBLEMS

A number of strategies are used to prevent behavioral, social, emotional, and academic difficulties in children. Primary prevention strategies are aimed at reducing the incidence of new cases of mental health problems; secondary prevention efforts are directed at reducing the severity and duration of disorders through early identification, diagnosis, and treatment (see 98). In practice, however, primary and secondary prevention often overlap. The common objective underlying all prevention efforts is to reduce the incidence of

mental health problems in the population and to reduce the need for more intensive and costly treatment services such as psychiatric hospitalization or other residential treatment (98).

### Primary Prevention

Primary prevention efforts are frequently directed at parents and educators. Sometimes they are aimed at the parents of children who are at high risk. To treat high-risk infants, for example,

programs train parents in different techniques for stimulating and giving attention to the infant. Other similar primary prevention interventions have been developed for particular groups (e.g., poor women) and teenage mothers (187,525).

Primary prevention methods have also been devised for the parents whose children are not known to be at high risk. Such methods include training manuals to help instruct parents in child-management techniques (e.g., 40,429,497), educational videotapes for inexperienced mothers (78), and parent education groups such as Parent Effectiveness Training (242,243). Although popular, some of these methods have been criticized for not meeting the needs of low-income families (110).

In school settings, primary prevention efforts include alcohol education programs in elementary schools (380) and mental health consultation services provided to teachers (see 408). Such efforts also include programs aimed at decreasing specific behaviors that are thought to predispose children to later problems in school adjustment. For example, one program employed intensive training in interpersonal, cognitive problem-solving for kindergarten children in the hopes of decreasing inhibited and impulsive behavior and enhancing social problem-solving skills (621).

Head Start and similar preschool child development programs are examples of an ongoing effort at primary prevention. Head Start was established as a national program in 1965 to provide enriched early childhood education for low-income children. Head Start also provides a range of other services, including health, nutrition, and social services. The program emphasizes parent and community involvement in the development and operation of the program, a feature that has proved effective (see ch. 9). However, Head Start has been criticized for devoting few resources and little attention to mental health services (308).

Somewhat different from other primary prevention programs are family support programs. In recent years, the importance of families for children's mental health has been widely acknowledged (290). Although families are often viewed as the primary contributors to mental illness in children, they are increasingly recognized as a



Photo credit: March of Dimes

Physically disabled children may be susceptible to mental health problems.

principal source of mental health and adaptation (693).

The idea of supporting families is not new, but the growth of a family support movement as a distinct and important aspect of children's mental health services is a fairly recent phenomenon (326,693). The family support movement can be said to be integrative in that it focuses on the needs and linkages between children, families, communities, and broader social systems. According to Weiss (693) and others (594), the family support movement evolved in part from early intervention and prevention programs such as Head Start. The finding that the most effective of these programs were those that actively involved parents—and the related idea that children at risk need an intervention approach that encompasses more than educational enrichment—pointed to the family as a necessary focus of intervention.

More recently, the family support movement has gained impetus from research underscoring

the importance of quality parent-child interactions in promoting children's social, emotional, and cognitive competence (e. g., 623). The development of family support programs has also been supported by recent trends in the delivery of social services. Such trends include increasing emphasis on the promotion of health and the prevention of illness, the use of self-help and mutual aid groups, and access and coordination of services through information and referral systems (334,693).

Finally, the family support movement is a response to the stresses faced by contemporary American families. Such stresses include demographic trends (e.g., increases in the numbers of single-parent and dual-career households) as well as broad social forces such as unemployment, economic uncertainty, and increased mobility and isolation of families.

The family support movement represents a diverse array of services and programs that share underlying assumptions and conceptual emphases more than a particular format or structure. Family support services range from a center-based program resembling traditional mental health service to practices such as corporate flexitime and daycare.

Family support programs are characterized by their focus on family strengths rather than deficits; their recognition that parents need and want information and support in carrying out their roles; an attempt to empower families and foster self-reliance; and their emphasis on the relationship not only between children and parents, but also between families and the sources of support in their communities.

According to Weiss (693), the dimensions on which family support programs vary include the type of family served (e.g., new families, single-parent families, families with special needs); service delivery mechanisms (e.g., newsletters, home visits, parent groups); program goals (e.g., child abuse prevention, home and school linkages, parent and child education); program settings (e.g., mental health centers, schools, churches, drop-in centers); staff composition (e.g., mental health and health professionals, educators, volunteers); and funding sources (private and public).

Two examples of family support programs are the Yale Child Welfare Research Program (594) and the Family Support Center Program (see 202). The Yale Child Welfare Research Program is different from other programs in that it is university based and includes outcome research as one of its major components. The Yale program is typical of family support interventions, however, in that it employs a multidisciplinary teamwork approach focused on the social and emotional adjustment of all family members. The goal of the Yale program's interventions is to enhance parent's ability to perform their caregiving roles and to solve their own life problems. Interventions are aimed at impoverished families considered at risk by virtue of the chronic stresses and limited resources associated with reduced socioeconomic status. Families receive home visits, pediatric care, daycare, developmental examinations, and psychological services as needed, and services are provided over a 2<sup>1/2</sup>-year period for each family. In a recent 10-year followup of the original program participants and an equivalent group of control families, the Yale program's interventions were found to have both positive and long-lasting effects (see ch. 9).

The Family Support Center Program is designed to reduce the incidence of child maltreatment in at-risk families by providing parents with support and guidance in a series of steps that emphasize progressively greater peer support and progressively less staff involvement. As parents advance in the program, they move from receiving direct staff support and consultation, to attending a "family school" with their children, to participating in a neighborhood support group. An evaluation of a Family Support Center Program (25, 202) is discussed in chapter 9.

## Secondary Prevention

Secondary prevention efforts for children who have begun to show signs of behavioral difficulties have been implemented in both home and school settings. Some secondary prevention efforts are aimed at training parents to deal directly with their children's problems. In one program (317,318), parents were taught to use behavioral methods to modify a range of behaviors in their

preschool children at home (e.g., reducing aggression and tantrums, and increasing eye contact, imitation, and vocalization). This program also involved parents in health-center-based activities in which they observed and were instructed in teaching activities aimed at enhancing their children's prosocial behavior and language skills.

One of the most extensively implemented and well-researched school-based secondary prevention programs is the Primary Mental Health Project (PMHP) of Cowen, et al. (128). This program was developed to remediate children's problems in the primary grades, a goal based on observations that early school problems frequently persist or increase over time and that they lead to

more serious mental health problems later in life (126,128). PMHP involves the delivery of individually based, remedial efforts to grade-school children who have been identified as having behavioral and academic difficulties (e.g., acting-out, withdrawal, and learning problems). Teacher aides meet with children on a regular basis during the school year, and individual goals are modified according to the child's changing needs. Additionally, mental health professionals serve as consultants to teachers and other school personnel. The PMHP model has been widely disseminated, and programs have operated in over 200 schools throughout the country (125).

## INTEGRATION OF MENTAL HEALTH AND OTHER SERVICES

As described in this chapter, the treatment and prevention of children's mental health problems occurs in a variety of settings—educational and other—outside the mental health care system. In addressing children's needs, therefore, it is important to consider the integration of mental health services with other services. Given the diverse settings in which children's mental health care is provided, it is perhaps not surprising that fragmentation of services is often reported (324,359).

Isaacs (310,311) has reviewed various methods of integrating systems, both at the level of entire systems or programs and at the level of individual children. State departments can cooperate at the administrative level to develop policy decisions together, to initiate programs jointly, or to share management and support services. Service programs can include staff from all systems. At the level of the individual child, agencies can collaborate on most stages of the treatment process, from case finding and evaluation to followup. Although each agency provides specialized services, staff from different services can collaborate in periodic case conferences, case teams, or case consultation.

According to Isaacs (312), a number of principles should undergird the organization of the children's mental health system. One is that children's mental health services should be integrated with

services that address a child's physical, mental, social, and intellectual needs while recognizing the developmental stages of the child and the needs of different groups of children and adolescents. Another principle is that services should be coordinated, with a single agency given responsibility for developing and coordinating the system of care at both local and State levels. Yet another important principle is that services should be delivered to the extent possible within the child's normal environment (i.e., home, school, health care setting), and, if such is not possible, within the least restrictive environment. Finally, early identification of problems should be promoted and the system of care should support a child's right to develop in a nurturing environment with positive adult relationships.

One important concept in the integration of children's services is that of the case manager or case advocate (359). A case manager or advocate is an individual or team, usually in the mental health system, who assumes responsibility for ensuring that the appropriate combination of services from all service systems is provided to a client. Case managers are conversant with the laws entitling children to services, such as Public Law 94-142, and ensure their application in individual cases by advocating on the child's behalf in school, in court, or within the mental health treatment program itself (359). They can maintain the

push for treatment within systems that are sometimes overwhelmed, disinclined to treat difficult children, and entangled in bureaucratic difficulties (359).

One of the most sophisticated models of case management has been developed by North Carolina. In this model, case managers are responsible for seeing that all facets of a child's evaluation and treatment are carried out. They continually review the treatment plan and monitor its implementation; one of their responsibilities is seeing to it that the disturbed child receives treatment in the least restrictive setting possible (50). In some instances, case managers locate and arrange for services outside the mental health system, such as homemaking systems for beleaguered mothers, that are nonetheless crucial to the stability of a disturbed child's family. In addition, they arrange for the adult service systems to continue care for children in need who are about to turn 18 (50).

## CONCLUSION

The educational system, the general health care system, the child welfare system, and the juvenile justice system present important opportunities to identify and help troubled children. Yet evidence suggests that the mental health problems of children involved with these systems are often poorly treated or not treated at all (358,595,645).

The variety of mental health programs potentially available to children would appear to require that such services be integrated across mo-

At present, the integration of mental health and other children's services is probably more of an ideal than a reality. In a review of State administrative structures for provision of coordinated services, Isaacs (313) concluded that despite a number of models, implementation of coordination plans often depends on the efforts of individual staff members, rather than on established systems and structures. In addition, Isaacs (313) found that even in States attempting coordination between the mental health system and other agencies, State education and health departments, which have the most frequent contact with children, were almost always excluded from coordination programs. The Federal Child and Adolescent Service System Program, described in chapter 10 of this background paper, was established in 1984 to help State mental health agencies coordinate care for one segment of the population of children with mental health problems—those who are severely emotionally disturbed.

dalities, providers, settings, and systems although in many cases there may be few services to integrate. The variety of mental health programs also suggests that evaluation of any one intervention program is likely to yield an incomplete picture of the nature and effectiveness of children's mental health care. Variables such as coordination of programs should be taken into account in the assessment of that care.