

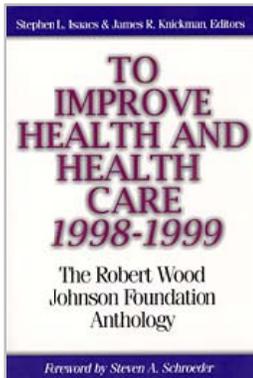
The Mental Health Services Program for Youth

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Editor's Introduction

Between 1985 and 1995, the Foundation funded a number of national demonstration programs that relied on communities rather than on institutions to care for people with a range of persistent health-related problems. Providing care in the community was a theme of Foundation-funded programs to serve people with chronic mental illness and with HIV or AIDS, the frail elderly and children with chronic mental health problems.

Leonard Saxe and Theodore Cross, as faculty members at the Heller School of Brandeis University, led a team that evaluated the Mental Health Services Program for Youth, or MHSPY. They place MHSPY within the broader context of efforts to reform services for children with mental health problems and then examine what happened under the program. The chapter takes the reader through the program's attempts to address the challenges related to creating, financing and coordinating community services.

As in the case of many Foundation-supported initiatives to support innovation in service delivery, it is difficult to reach bottom-line assessments: Were the new systems of care better or worse than their predecessors? Did youth fare better under the new systems of care? For better or worse, the initiatives vary with local conditions that make scientific assessment difficult if not impossible to make. And the initiatives often do not address all of the issues needed to assess outcomes. Questions remain, but Saxe and Cross do conclude that MHSPY was able to provide services in the community and to keep children with mental health problems from being institutionalized.

Children are cherished as our most precious resource, but if we are judged by how the health system treats them, there is a contradiction between our words and our deeds. The neglect of children is particularly evident in the mental health care system, where children's services have often languished as a stepchild of adult mental health, which is itself a resource-starved sibling to physical health care. Although reform efforts have improved children's services over the past twenty-five years—from a time when large numbers of children were institutionalized without *any* effective treatment—they remain woefully inadequate. An attempt to develop services was made in the 1970s, but by the early eighties it was clear that children with emotional disorders were often not able to get access to these services.

The recognition that children were underserved catalyzed a coalition of parents, professionals and researchers to press for reform. There was consensus that existing services inappropriately removed children from their homes and their community and served only a fraction of the children in need.¹ The reformers proposed the development of comprehensive systems of community-based care, oriented to providing appropriate care to each child with a mental disorder and including parents as key caregivers.

The disturbing findings of a 1982 Children's Defense Fund report by Jane Knitzer, entitled *Unclaimed Children*,² provided an early prompt for reform. Knitzer's survey of state agencies documented the deplorable state of children's mental health services available nationwide. She found that only a minority of the more than two million American children with severe emotional disturbances received adequate mental health services. The report concluded that children's services were not coordinated and were not provided to children within their homes and communities.

These conclusions were substantiated in a study that we and our colleagues developed for Congress's Office of Technology Assessment.³ Epidemiological estimates indicated that more than 12 percent of the nation's children had a diagnosable mental disorder, with half of these children conservatively estimated to have a serious mental disorder. Yet the mental health care system concentrated almost all of its resources on a small number of children placed in institutional settings (such as psychiatric hospitals and residential treatment centers), while the needs of the majority were inappropriately ignored.

Child and Adolescent Service System Program

In 1986, the federal government established the Child and Adolescent Service System Program, or CASSP, to help states reorganize their agencies responsible for providing mental health services to children and their families. A goal was to ensure collaboration among child-serving agencies. Typically,

although children with serious emotional disorders were served by education and child welfare agencies as well as traditional mental health providers, the collaboration among these agencies had been minimal. The CASSP philosophy envisioned the child as the focus of mental health services and the professional caregivers as partners with the families serving these children. It promoted individualized care provided in the least restrictive setting and in the community. Ideally, the services available in the community would make it unnecessary to place children in institutional settings. And, in theory, limited reliance on psychiatric hospitals or residential treatment centers could reduce the cost of care.

The system of care would contain a continuum of services of varying intensity and intrusion in children's lives. The services would range from outpatient psychotherapy and parental guidance, day treatment, therapeutic foster care, and intensive case management to intensive services such as residential treatment and psychiatric hospitalization. Unnecessary duplication and gaps in service were to be avoided. Case managers, interagency planning and case review teams would be used to ensure coordination and a close fit of services to child and family needs. In addition, parental experience and involvement was valued and needed to ensure the responsiveness of those services to a child's needs.

Although CASSP had a profound effect on how states organized care through an unprecedented degree of interagency coordination, it was a small program constrained in scope and power. Its funds were both limited and restricted, and could not be used to support services directly or to fill gaps in existing services. All told, the initiative had a fiscal life span of ten years.

THE MENTAL HEALTH SERVICES PROGRAM FOR YOUTH

The Robert Wood Johnson Foundation saw a need to help communities develop more effective mental health services for children with emotional disorders and to help fill the funding gaps. In 1988, two years after CASSP was established, the Mental Health Services Program for Youth, or MHSPY, was conceived. It was intended to put into effect the reforms that had broad support among professionals and parents but that had not been widely adopted. Structured by the Foundation as a national demonstration, MHSPY was designed to test coordinated, community-based mental health care for children. Parallel to CASSP, the implicit theory was that children, even those with the most serious mental disorders, could be treated within their community, provided that a broad range of services was available and that the family, the school and the other settings in which these children lived were made partners in developing supportive services. Creating a system of care was designed to reduce reliance on out-of-home placements

for children with serious mental disorders, and to make more efficient use of limited mental health resources.

Because the idea of coordinated community-based mental health services was consistent with broader efforts during the 1980s to reduce the federal government's responsibility for health care, communities were given considerable latitude. Each participating community was expected to develop a structure and program that fit its needs and could eventually be supported by the community, independent of the Robert Wood Johnson Foundation's support. Developing cost-effective solutions was central to the program's design. Institutional care for children with serious emotional disorders was too expensive, and resources were not available to expand it. Community-based care was thought to be less resource-intensive. Thus, the program idea appealed both to those who were concerned with reducing the costs of health and social programs and to those who wanted more effective and accessible services for children. It was, perhaps, an unusual alliance between budget-conscious officials and advocates for children.

The MHSPY demonstration aimed explicitly at changing the organization, the financing and the agency responsibility for providing mental health services. Eight communities participated, representing diverse geographic and demographic areas. The sites ranged from portions of large cities, such as Cleveland and San Francisco, to the entire state of Vermont and several rural and semi-urban counties of North Carolina, as well as communities in Kentucky, Wisconsin, Pennsylvania and Oregon (see Table 9.1 for a listing of MHSPY sites). Each project was a joint endeavor between state agencies and local communities. The Foundation initially invested \$20 million in the program, with funds designed to help participating communities reorganize services and develop new services.

Each of the communities that participated was funded to serve the children with the most serious emotional and behavioral problems. These included specific psychiatric disorders such as conduct disorder, major depressive disorder, borderline personality disorder and pervasive developmental disorder. Many children had dual or multiple diagnoses. The children's histories were compelling and, perhaps, more telling than their diagnoses. Many had experienced severe abuse or neglect, multiple residential or foster care placements, or a long history of problems and unsuccessful interventions in schools, outpatient clinics, child welfare agencies and juvenile courts.

Sites aimed at avoiding the hospitalization of children with serious mental illness through a number of methods: expanding the community's continuum of care, providing case management with an

individualized care philosophy, and financing strategies that allowed the flexible use of treatment money. Collaborations among mental health, child welfare, education, and, with one exception, juvenile justice agencies, were common in all the sites. Projects had to create mechanisms for interagency coordination, involve parents and other caregivers, and expand community-based services. Expanded services often required the development of new or pilot services, such as therapeutic foster care, crisis intervention, independent living programs and intensive home visiting. The emphasis was on flexible, intensive interventions provided in the community.

The development of a system of care was not a discrete intervention, but a complex organization of people, resources and procedures. The particular system developed depended on the specific demographics, geography, economics, history, law, policy and individual relationships present in a site. The Foundation, realizing that different models were necessary, encouraged diversity. MHSPY sites resembled one another in their development of specific services and mechanisms for providing and coordinating care—for example, case management, interagency treatment planning and programming, flexible funding, individualized care and community-based interventions. But the organization of the projects varied greatly, making it difficult to develop an organizational chart for a system of care.

Thus, for example, Vermont developed a system structured around state and local interagency planning teams as well as interagency treatment teams, all based within the Department of Mental Health and using more or less traditional funding sources. Similarly, Kentucky based its system on a statewide interagency system, mobile case managers and interagency treatment teams at the local level. The Madison, Wisconsin, site developed its system around a private agency contracting with multiple private providers, using a capitated managed care approach. The San Francisco, California, project developed a new organization with workers from various agencies coming together to develop ethnically diverse, neighborhood-based programs; that project also used a new managed-care model. The Cleveland, Ohio, site based its system on an effective partnership between a private human services program with strong community ties and a forward-thinking county mental health board. North Carolina relied on strong county public mental health organizations backed by a strong state mental health department. It joined a state-run managed care experiment toward the end of the project. The Oregon project centered on a social welfare agency with skilled clinical social workers. In Pennsylvania, the site relied on a long-standing local interagency planning team. The specific organizational strategies each site used to move toward a system of care varied, even though the system principles were uniform across sites.

EVALUATION

The evaluation of MHSPY was designed to assess the feasibility of the program and its impact on service delivery. The focus was on how changes in the organization of a community's mental health system for children could allow children to be treated in their normal environment and could reduce the need for placements in hospitals and residential treatment centers. The evaluation, which was conducted over a five-year period beginning in 1990, monitored program implementation in each community and tracked program effects. The evaluation emphasized the description of the diversity of forms of an effective system of care and how implementation of systems of care varied by population, geography, financing, administrative and legal structures, and local history. The evaluation also sought to determine whether there were common lessons across communities.⁴

The evaluation data support the hypothesis that systems of care are indeed feasible with the appropriate organizational and financial support.⁵ All sites expanded the range and the flexibility of services available to children. Therapeutic foster care providing homes with specially trained and supported foster parents was increasingly available. Weary parents of children with mental disorders had greater access to respite care, and emotionally troubled teenagers with inadequate homes had greater access to independent living programs that helped them learn to live on their own. Specific services that became available to more youths and families included crisis intervention and child mental health screening. Over the course of the project, case management became universal. All sites seemed to have at least one frequently used, intensive, intermediate service between outpatient services and residential or hospital treatment. The specific intermediate services varied from site to site and included intensive home-based intervention, therapeutic foster care, group homes and independent living programs. For example, a majority of Kentucky clients received intensive home-based treatment during their first three months, and nearly half in Vermont received therapeutic foster care.

Community-Based Care

A key issue was whether care could be provided in the community. Each MHSPY site tried to maintain children at risk of psychiatric hospitalization in the community by providing for their multiple service needs. There is substantial evidence that the demonstration accomplished this goal. Service data from the client information system indicate that hospitalization and residential treatment were rarely used. For most sites, the percentage of MHSPY children in residential or hospital treatment was 5 percent or less (with one exception, where 10 percent were hospitalized at the beginning of treatment and 8 percent at twelve months of treatment). Low hospitalization rates were achieved despite the fact that many of the children and adolescents had histories of residential or hospital treatment, and were selected because they

were at high risk for institutional placement. Indeed, some sites explicitly selected children who were in residential or hospital settings at the beginning of the demonstration and brought them back to the community.

Changes in financing services were instrumental to offering a wider range of services, avoiding hospitalization, and providing a better fit between needs and services. In six sites, different agencies in the system of care pooled funding for services, so that money originating from mental health, child protection and education agencies could be used together for a wide array of services. Accounts for funds were created, providing money to cover the needs of individual children. Thus, sensible interventions could be provided, such as a yard fence for an impulsive child who had no place to play safely at his home or cooking lessons for an adolescent with emotional problems who had found this a productive outlet. Most sites made innovative use of federal entitlements, in particular the Medicaid 1915(a) option. This option allows states to pay for "services not included in the state plan." The money can be used flexibly for whatever services are needed. Altogether, these funding mechanisms were used to address the totality of the physical health, mental health, educational and social needs of children and families. Therapeutic, family support and other services are essential if children are to be maintained in their home environments. That children are not hospitalized does not diminish their need for services; in some cases, it may increase the demands.

Systems of Care

Whether sites could function as systems of care was also a central question. The expectation was that child-serving agencies would change to work in partnership with families, coordinate with other organizations and provide child-centered treatment. During the five-year implementation of MHSPY, many of these changes were evident. Some sites consolidated existing interagency structures and extended their influence on local practices. They developed new services, set up training programs in system of care models, and adapted innovative financing methods. Interagency working groups emerged from the central interagency structures to deal with specific issues such as training, outcomes, programming, case review, management of specialized services and technical assistance to local communities. By the end of the project, most of the sites had broadened the range of children served. In many cases, administrative changes were accompanied by changes in governance, with increased local management of services and use of funds.

In addition to the development of interagency structures, most sites reported a qualitative increase in the degree of collaboration. Staff in several sites reported a process in which the different organizations in the

system of care became more engaged over time and more productive working together. Local community agencies in each site gradually absorbed system-of-care principles that were previously little known. In Cleveland, Ohio, for example, the child welfare agency and private agencies that traditionally had contracts for residential beds gradually developed an investment in community-based alternatives. Kentucky increased collaboration by training education officials in how to access mental health and social service funding.

Interagency relationships flourished in part because MHSPY projects had funds and services to offer and case managers with skills in individualized care for children that other agencies found difficult to manage. In Cleveland, for example, child welfare workers came to rely on MHSPY case managers because they were able to provide support to clients, design individualized services and use flexible Medicaid funds. In San Francisco, empowered by control over flexible Medicaid funds, the MHSPY project developed a culturally sensitive model of care that worked with neighborhood agencies to create packages of services for clients.

Nevertheless, despite the substantial development of services and systems, the sites fell short of fully developed systems of care. One issue was the difficulty of establishing services to cover more than a few well-chosen points on the continuum of care. Typically, each site had at least some gaps in the continuum of care as it was originally envisioned. Often, this was because some child-serving agencies remained outside the interagency agreement and systems of care, or financing innovations produced limited funding pools, or both. In one case, there was a struggle to maintain even a small number of residential treatment beds for those children who temporarily needed such services. There were also chronic problems linking the social welfare system to other agencies responsible for children with emotional disorders. By the time support from the Robert Wood Johnson Foundation had ended, each site was still working to adopt system of care principles.

Continuation

One striking accomplishment was the staying power of the partial systems of care that were developed by the projects. At every site but Pennsylvania, most of the services and structures created by MHSPY survived beyond the end of Foundation support. The sites replaced MHSPY funds from a variety of sources, including county and state money and federal grants. Several innovations developed in part or wholly through MHSPY were incorporated into managed mental health care plans developed by the states.

Collaboration between Health Professionals and Parents

The partnership between professionals and parents that was one goal of MHSPY was partly realized. The close relationship between case managers and parents at many sites was evident from parent interviews, so parents often felt comfortable reaching out to their case managers for a variety of needs. Parent participation in the development and the management of the system of care was, however, underdeveloped in most sites, although in Vermont a strong family advocacy group took the initiative to begin and maintain a respite program for parents, and had a strong presence on the state interagency planning team.

Case Example

The case of a child referred to as Iola illustrates how the system of care functions in the community. Iola was an adolescent whose childhood was marred by trauma and instability: her father's death when she was a toddler, placement in foster care at age three, incest at the hands of her adoptive father, placement in four foster homes over six months as a twelve-year-old, neuroleptic medication at age thirteen, residential treatment from age thirteen to sixteen, and finally placement in the community at age seventeen. Her school records showed a history of destructive and aggressive behavior, inattentiveness, tantrums and self-abuse. She abused drugs and alcohol and developed a cocaine dependence that led her to trade sex for drugs. Outpatient treatment, foster care, psychiatric medication, residential treatment and juvenile detention were all inadequate. Serving her was a challenge because of her hostile, manipulative, and suicidal behavior and her tendency to run away from placements.

Iola was placed in an independent living program with multiple services. The treatment team doubted that she could avoid incarceration unless she developed the capacity to live on her own. The project provided her with an apartment, allowances for groceries and clothes, and daily advice and monitoring from a case manager. Her treatment team included staff members from mental health, child protection, school and juvenile justice agencies as well as a motorcycle policeman that she had befriended. Her mother was also included, but could not contribute much because of her own difficulties. The team shared responsibility for the support she needed, and worked with school and probation officials to help them respond to her emotional disturbance. Only after months of support from the team was she able to tolerate individual psychotherapy to address her trauma. With support, she completed high school, obtained a job, began to write about her life and started taking care of daily living. Interwoven with these positive developments, however, were occasional encounters with the police and the intermittent use of alcohol and drugs. The case of Iola illustrates how the MHSPY system of care developed flexible, multipronged methods for dealing with very difficult adolescents with a poor prognosis. It shows how a continuum of services and interagency coordination can make community care feasible, and how an evaluation must take into account how profoundly these young people have been hurt.⁶

Building Programs Around Children's and Their Families' Needs

The evaluation did not allow for an objective assessment of treatment effectiveness. Efficiency is not equivalent to effectiveness, and it is unclear, given the current knowledge base in children's mental health, whether making available a set of desirable services is going to ameliorate the disturbance of children with serious emotional disorders. Some researchers have argued that there is little data to support the real-world effectiveness of mental health treatments for children, and, therefore, organizing effective systems is not going to have much impact.⁷ Qualitative evaluation data suggest that the sites most successful in programmatic terms seemed to be those that were able to adapt systems to the needs of children and their families. All sites conducted elaborate assessment and decision-making about treatment programs and planning for individual children and families. Perhaps such programs and plans are the key to effective treatment. Thus, MHSPY's most important idea may not be coordinated systems of care but the idea that services must be designed specifically around the needs of children and families.

LESSONS LEARNED

America's health care and social systems have undergone profound change, fueled not only by the need to control costs and expand services but also by political changes that place increased responsibility on those who seek help for health care problems. MHSPY's lessons need to be understood in terms of these larger changes. What was clear is that, although individuals and families have a potentially important role, the way professional services and community resources are used is critical. When MHSPY was launched, the gap between the rhetoric and the reality of children's mental health care was substantial. Professionals, parents and advocates believed that they knew what was wrong with services, and the promise of MHSPY was that it was going to demonstrate how reforming delivery would provide more effective and efficient care. In part because MHSPY was established as a nonexperimental demonstration program—that is, there were no comparisons with control groups—it is difficult to draw definitive conclusions about whether it was successful in terms of ultimate outcomes. In several ways, external events outpaced the demonstration and made its lessons even more difficult to discern.

Treatment Effectiveness: Lessons from the Fort Bragg Experiment and MHSPY
The Fort Bragg Child and Adolescent Mental Health Demonstration began in 1990, after MHSPY, and was explicitly developed as a quasi-experiment to test the effectiveness of system-of-care services to children with emotional disorders. Funded by the Department of Defense and the National Institute of Mental Health, the Fort Bragg demonstration was conducted with children of military personnel. In collaboration with the state of North Carolina, the demonstration developed a full continuum of

children's mental health services for military dependents. An independent evaluation was conducted to assess the conduct of the demonstration and its impact on the children served. The evaluation compared outcomes in the Fort Bragg community with outcomes at two comparable military sites.

Like MHSPY, the Fort Bragg continuum of care was designed to offer a wide range of services to be more responsive to the needs of children and families and avoid unnecessarily restrictive treatments, such as psychiatric hospitalization. The demonstration emphasized intermediate services such as in-home crisis stabilization, after-school group treatment, therapeutic foster care and crisis management to help fill the gap between outpatient psychotherapy and institutional treatment. However, unlike the MHSPY sites, the Fort Bragg demonstration was conducted within a closed system of health care provided by the military for its dependents, an environment that more closely resembled a managed health care organization than the MHSPY sites.

The results of the evaluation indicate that care provided during the demonstration expanded dramatically.⁸ Compared with baseline data, it served three times the number of children, far more than were served at the two comparison sites. As was the case with MHSPY, there is strong evidence that the continuum was put in place, and there is further evidence that services were of high caliber. Children in the demonstration were less likely to use hospital and residential treatment but more likely to use intermediate services. They also had significantly more therapy visits and longer time in treatment. Clinical outcomes were generally no different, however; children at both demonstration and comparison sites improved, but the demonstration did not lead to better scores on mental health measures. Moreover, the demonstration was more expensive, spending 1.5 times as much per child as the comparison site.⁹

The Fort Bragg evaluation attracted considerable attention because it challenged the assumption that a continuum of care improves access to care and enhances children's mental health outcomes. To the consternation of those who advocate coordinated systems of care, the results suggest that children are not necessarily better off as a result of being served by the continuum. Is it possible, as Bickman and others suggest, that we have misplaced our focus, and that we need to return to basics and develop more effective treatments?¹⁰ Or is this a narrow view of the findings from the Fort Bragg demonstration, one that overgeneralizes the results?¹¹

Although the Fort Bragg study did not find differences in outcomes between the demonstration and comparison groups, the findings are consistent with the MHSPY results showing that a comprehensive continuum of care can be developed and can increase access to services for children in need. Moreover, the children's improvement on outcomes were relatively impressive in both the demonstration and comparison groups, suggesting positive effects of mental health treatment across the study.¹² A problem with the study was that the comparison group—other military communities—actually received intensive and coordinated services far better than those typically available to children outside of military families. The rates of hospitalization and residential care were, however, lower in the treatment site, and confirm that children, even those with the most serious mental illness, can be effectively treated outside of institutional settings.

The lack of superiority in clinical outcomes and high costs suggest that health professionals are only at the early stage of understanding how to provide effective and cost-efficient mental health care. Clearly, we need to better understand how the delivery of services affects outcome. If, in fact, the present assumption is correct—that the effectiveness of treatment is linked to how closely one can match treatments with children's and families' needs—it is essential that we develop a continuum of research. The continuum needs to include basic research studies as well as efforts to test models of caregiving in actual communities. The MHSPY demonstration and the Fort Bragg study make clear that experiments with managing mental health care for children are still very new and that the question is not whether they should be done, but how.

Patient-Focused Care

Although there are many ways to describe the new perspective incorporated in the systems-of-care model to providing services to children with mental disorders, it is clear that a system of care embodies fundamental changes in the way services are provided. For present purposes, it will be characterized as a patient-focused approach for restructuring health services, where clinical needs are placed at the fore and health professionals have to form a partnership with patients and families to make key decisions. The claim cannot yet be made that this will bring about more effective care, but it provides a way to think about developing and testing more effective treatment.

Patient-focused care should not be revolutionary, but the nation has experienced several decades of rapid progress in health technology and a concomitant institutionalization of health services, where the patient's needs were often subordinated. Decision-making power is now shared in an uneasy balance between those responsible for financing care and the institutions that provide health services. The new

patient-centered approach to children's mental health services takes back this authority and gives a central role to parents and, in some cases, children and adolescents.

The development of a new model has not happened *de novo*. Many have pointed to the need to reshape health and social systems to respond to the needs of those served.¹³ For children, the guiding principles are that care must be community- and family-based *and* comprehensive.¹⁴ This is because families have the responsibility for children, but it is clear that they cannot cope alone with problems such as serious mental illness. They need the help of professionals, but professionals cannot have the sole responsibility.

One of our observations in MHSPY was that the new service most often used by families was respite. Respite care enabled a family with a child who had a mental illness to have help at home. Sometimes, a respite worker was simply an extra hand; in other cases, the respite worker was able to relieve the parents and allow them to work or deal with other responsibilities. Anecdotal evidence suggests that respite was a critical service that allowed children in MHSPY sites, even those whose behavior required constant attention, to be maintained in their community. Respite care exemplifies the interdependence of families and professionals.

There has been a major change in perspective by those responsible for federal and state initiatives. Categorical federal programs have been replaced by block grants to the states, and mandates have been replaced with broad new local authority. Centralized health care reform is not being discussed now, and, instead, smaller reforms have been introduced. In most cases, individuals have more responsibility, financial and other, for obtaining care. One of MHSPY's lessons is that there is an alternative to the two extremes of centralized health care and individually directed health care. MHSPY and Fort Bragg suggest that local communities can develop systems that help individuals. Because families cannot deal with serious health problems alone, some way to provide professional support and resources to those in need must be found. MHSPY-sponsored programs were able to mobilize a variety of resources to provide individually tailored services, and not all of these were from traditional health care providers.

CONCLUSION

Children have been victims of our society's inability to resolve fundamental problems with our health and social systems. They are more likely than adults to live in poverty and to lack health insurance, and they have the most difficult problems getting access to appropriate health care. Improving children's health and their ability to function should be a cornerstone of any reform of the health system, if for no

other reason than the long-term benefits for child development.

Whether the issue is education, juvenile justice, or mental or physical health, the MHSPY approach of taking an integrated view of children's needs seems a useful way to reconsider the help we provide. The Robert Wood Johnson Foundation's experience with MHSPY does not provide unequivocal evidence to support the MHSPY approach, but the idea of children as part of a family and a community seems so obvious that one wonders how we could have allowed our programs to stray from it. The village cannot raise the child, perhaps, but neither can the family do so without the support of its community. Children with serious mental illness are an extreme example, but how we treat them is symbolic of how we regard all children. Our failure to provide effective and efficient services for these children make them more visible, but the underlying principles are universal. All children need both their homes and the support of those in the communities in which they live.

Notes

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¹ Institute of Medicine, *Research on Children and Adolescents with Mental, Behavioral and Developmental Disorders: Mobilizing a National Initiative* (Washington, D.C.: National Academy Press, 1989).

² J. Knitzer, *Unclaimed Children* (Washington, D.C.: Children's Defense Fund, 1982).

³ L. Saxe, T. P. Cross, N. Silverman and W. F. Batchelor, with D. Dougherty, *Children's Mental Health: Problems and Services* (Durham, N.C.: Duke University Press, 1987; originally published by the Office of Technology Assessment, U.S. Congress, OTA-B P-H-33; Washington, D.C.).

⁴ Three types of data were collected: *Organizational Assessment*: Detailed case studies were developed for each of the eight communities to provide an understanding of how care was organized and financed. Site documents were reviewed and interviews, focus groups, and observational studies were conducted. *Client Information*: A common information system was developed and later adapted for each site to provide data on demographics, mental health problems, treatment plans and services provided. *Clinical Assessment Conferences*: Conducted by expert clinicians on a sample of patients and their families at each site, clinical assessment conferences provided an analysis of the quality of care and an appraisal of the contribution by the interagency system of care to the child's treatment.

⁵ T. P. Cross and L. Saxe, "Many Hands Make Mental Health Systems of Care a Reality: Lessons from the Mental Health Services Program for Youth," in C. T. Nixon and D. A. Northrup (eds.), *Children's Mental Health Services: Research, Policy and Evaluation* (Thousand Oaks, Calif.: Sage, 1997), pp. 45–72.

⁶ A.J. Solnit, J. Adnopoz, L. Saxe, J. Gardner and T. Fallon, "Evaluating Systems of Care for Children: Utility of the Clinical Case Conference," *American Journal of Orthopsychiatry* 67, 1997, 554.

⁷ J. R. Weisz, B. Weiss, S. S. Han, D. A. Granger and T. Morton, "Effects of Psychotherapy With Children and Adolescents Revisited: A Meta-Analysis of Treatment Outcome Studies," *Psychological Bulletin* 117(3), 1995, 450; J. R. Weisz, S. S. Han and S. M. Valeri, "More of What? Issues Raised by the Fort Bragg Study," *American Psychologist* 52, 1997, 541.

⁸ See, for example, L. Bickman, "Reinterpreting the Fort Bragg Evaluation Findings: The Message Does Not Change," *Journal of Mental Health Administration* 23(1), 1996, 137–145.

⁹ L. Bickman, P. R. Guthrie, E. M. Foster, E. W. Lambert, W. T. Summerfelt, C. S. Breda and C. A. Heflinger, *Evaluating Managed Mental Health Services: The Fort Bragg Experiment* (New York: Plenum, 1995).

¹⁰ See note 7.

¹¹ L. B. Behar, "The Fort Bragg Evaluation: A Snapshot in Time," *American Psychologist* 52, 1997, 557–559; see also note 6.

¹² K. Hoagwood, "Interpreting Nullity: The Fort Bragg Experiment: A Comparative Success or Failure?" *American Psychologist* 52, 1997, 546–550.

¹³ See, for example, L. B. Schorr, *Within Our Reach: Breaking the Cycle of Disadvantage* (New York: Anchor Books, Doubleday, 1989).

¹⁴ Children's Defense Fund, *The State of America's Children: 1992* (Washington, D.C.: Children's Defense Fund, 1992); National Commission on Children, *Beyond Rhetoric: A New American Agenda for Children and Families*, final report of the National Commission on Children (Washington, D.C.: Government Printing Office, 1991).

TABLES

9.1 MHSPY Sites