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ABSTRACT

This paper introduces a framework for conceptualizing a system of care for children and youth with severe emotional or behavioral disorders built on a child development perspective. The approach focuses on developmental transitions which all children and youth experience. Such transitions include entry into school, negotiating the challenges associated with the teen years in modern society, and emancipation from home. The first tier of the model includes a continuum of services that focuses on service and policies which promote the health development of children and youth while attempting to prevent serious mental health problems before they arise. Early identification and appropriate referral become crucial tasks. The second tier of this model includes the continuum of services for those children who have received clinical diagnosis. This continuum would include such programs or systems as the Early Prevention Screening and Diagnostic Treatment Program, special education classes, a range of mental health programs, and programs for specific sub-populations, such as adolescents with chemical dependency and eating disorders. The services that should be offered at each transition stage are described. (Contains 11 references.) (CR)

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System of Care for Youth with Severe Emotional or Behavioral Disorders: A Developmental Model

Introduction

The current system of care literature identifies core values and guiding principles for developing an ideal system of care, often within a framework of a continuum of care, in terms of the degree of restrictiveness of the settings in which children and youth with severe emotional disturbance are placed (Stroul & Friedman, 1988). Friedman and Kutash (1992) have argued that one of the challenges in the child mental health field is to shift to an early intervention focus. Identifying and intervening in children's problems at earlier ages may make it possible to modestly loosen the grip that poverty and social class have on their future prospects (Schorr, 1991). Kahn and Kammerman (1992) further argued that, in theory, one of the options for designing a more powerful system of care is to emphasize the role of socialization and child developmental programs, versus treatment services.

This summary introduces a framework for conceptualizing a system of care built on a child development perspective. What is the rationale for conceptualizing and designing a system of care in this developmentally sensitive manner? First, such an approach focuses on developmental transitions which all children and youth experience. Such transitions include entry into school, negotiating the challenges associated with the teen years in modern society, and emancipation from home. In addition, these transitions, normal for many children and youth, are overlaid by additional transitional events such as divorce, remarriage, and the death of a family member. When added to routine transitions, these events pose additional adaptive burdens which place such children at risk for emotional and/or behavioral disturbance. Furthermore, the literature clearly shows that poverty is highly correlated with mental health problems for both children and adults. This cluster of factors, which this model seeks to highlight, provides

insights into the dynamics by which children become at risk for severe emotional or behavioral disturbance.

Throughout the developmental stages, a system of care built around a developmental model would help identify key actors and systems of social service delivery. Beyond identifying key actors, however, it is also necessary to describe those key systems which impact most heavily on both healthy and clinically identified children and youth. For example, NACTS found that the participants in its clinical sample typically used multiple systems of care, which included schools, mental health, child welfare, corrections, and vocational rehabilitation. However, children at different periods in the developmental continuum tended to demonstrate different patterns of service system usage. For example, in the NACTS study, most children initially received service from the mental health system and schools. Later, many of these children came in contact with the child welfare system and the correctional system. Indeed, the transition that occurs when children move from status as clients in the mental health system to being relabeled criminally deviant by the correctional system warrants further analysis and policy development. This is particularly true for those children who are at high risk for coming into contact with the criminal justice system, such as clinical groups diagnosed with conduct disorder and attention deficiencies disorder. Job placement programs (e.g., vocational rehabilitation, etc.) represent a potential resource in facilitating the last transition in a child's developmental period, resulting in emancipation from one's family.

England and Cole (1992) note that service delivery should be organized to respond consistently to the ever changing needs of young clients who are growing and developing. Duchnowski and Friedman (1990) further argue that there is a need for viewing the community system as the unit of analysis in research, rather than simply looking at small components of the system. A service system organized around developmental principles addresses both of these concerns by emphasizing a community wide continuum of care conceptualized across the developmental period, from birth to twenty-two of age.

The first tier of a model for a developmentally focused system of care includes a continuum of services which focuses on those services and policies which promote the health development of our nation's children and youth. This continuum would include both health and social service providers (e.g., parental care, well baby clinics, day care, head start, schools, churches, family planning clinics, drug prevention programs, and vocational rehabilitation). These programs primarily focus on non-clinically impaired children and youth, but often include children who are at serious risk for emotional and behavioral disorders. As a result, caretakers such as parents, clergy, school personnel, day care facilities, and primary care physicians, become key

actors in the lives of these children. This first level in this model performs the important function of promoting good health and mental health, while attempting to prevent serious mental health problems before they arise. Early identification and appropriate referral become crucial tasks for these actors and systems.

The second tier in this model describes the continuum of services for those children who have received clinical diagnoses. This continuum would include such programs or systems as The Early Prevention Screening and Diagnostic Treatment (EPSDT) program, special education classes, a range of mental health programs from outpatient to residential treatment programs, and programs for specific sub-populations, such as adolescents with chemical dependency and eating disorders.

Key Transitions and Implications

Early Childhood

This model, by virtue of focusing on the entire developmental period, focuses attention on early stages of development, where child mental health problems might be identified and addressed, while they may be still manageable. NACTS data indicate, for example, that child mental health problems were identified for nearly half (48.3%) of their sample children prior to entry into school (Newcomb et al., 1995), highlighting the importance of early identification and intervention. Furthermore, parents were the people most likely to first notice that a problem exists in their sample (57.2%). Pediatricians and family practitioners are also potential sources of early identification, but they have been under-utilized. Less than two percent of the children in the NACTS sample had problems first noticed by doctors. Similarly, clergy are an under-utilized resource for early identification of problems. These actors should be involved in this process at the community level through in-service trainings provided by mental health practitioners. Psychiatrists, for example, may be more viable trainers for medical personnel, with other mental health professions providing such workshops to other identified actors in the community.

School Entry

The next major developmental transition centers on entry into school, and the subsequent expansion of the child's social world, providing children both opportunities and developmental challenges. Knoff and Batsche (1990) argue that schools must be viewed, in a developmental sense, as a primary intervention environment for all children, especially for those who exhibit educational and mental health problems or concerns. One such effort at strengthening services to children and youth, within these almost universal and natural settings, is a major initiative of the Florida Department of Education to develop "full service schools" in which many mental health services are located on site

in which many mental health services are located on site (Florida Mental Health Institute, 1991). Morse (1993) has provided a model of the roles schools could play in the prevention of mental health problems in children and youth.

The Teen Years

These children and youth then are required to negotiate transition from elementary schools to middle, junior, and senior high schools. At the present time in the United States, there is an alarmingly high level of interrelated negative outcomes for young people. For many teens, these outcomes include dropping out of school, substance abuse, aggressive behavior, emotional disturbance, teen pregnancy, unemployment, and criminal behavior (Florida Mental Health Institute, 1991). The increased complexity of the adolescent's social world, in combination with the multiple crises that often accompany this developmental time frame, place tremendous burdens on the multiple systems in which these children are engaged, as well as on the families and children, themselves. Thus, it is imperative that communities and families need to marshal all of the resources available to them as well as to develop new programs and strategies. A critical systems issue during this developmental period centers on the transition of many youth from receiving treatment in the mental health system to being processed through the juvenile corrections system. Over one million children and adolescents a year are processed through the juvenile courts, many of whom are children with serious emotional and/or behavioral disturbance.

Entering Adulthood

The last major transition these youth experience is the transition to adulthood. Youth with clinical diagnoses often have a particularly difficult task in moving towards independence. Unfortunately, this is an area in which these youths are typically underserved, and they under-utilize those services which are available. Indeed, Stroul and Friedman (1988) identify support for the transition to adulthood as one of their ten principles underlying an optimal system of care. They recognize that children who "age out" of the system of care become young adults who often need long-term mental health care, vocational services, and a range of other support services. Thus, it becomes important to develop functional linkages with relevant adult agencies.

Conclusion

A developmentally focused system of care would have the advantage of building on current trends in the recent paradigm shift in child and adolescent mental health and would support principles of care already described in the literature. Costello et al. (1993) note, for example, that "in the past decade, child psychiatric epidemiology has started

to look at both public health and causal aspects of epidemiology from a developmental point of view."

Stroul and Friedman (1988) articulated both core values and guiding principles for an ideal system of care. This child developmental model, with its emphasis on the role of parents and its community focus, is consistent with both of their core values. Specifically, their emphasis on early identification and intervention and on a smooth transition into the adult service system as they reach maturity are issues that a developmentally focused system of care would at least attempt to address. Similarly, the National Commission on Child Welfare and Family Preservation argued that states should offer a three part system of care for children and families. The first component would involve a universal infrastructure for all families and include such services as prenatal care, parenting education, and developmental services. A strong pro active family policy would be a necessary and potentially powerful base upon which to build a functional child mental health system attuned to a developmental focus. This summary has provided a beginning framework for such a system of care.

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