# MENTAL HEALTH POLICY IN THE UNITED STATES

## CHILD AND ADOLESCENT MENTAL HEALTH POLICY

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Abstract: This lecture draws from two quite different dimensions of child mental health policy—(1) the need for services for children and adolescents with emotional disturbance and (2) the responsibility of society to provide the conditions necessary for successful psychological development.

With regard to the need for services, I distinguish between the needs of children and adolescents with mild or moderate emotional disturbance and those with serious emotional disturbance (SED), emphasizing that those with SED need a broad array of services and supports at home, in the schools, and in their communities. This broad array cuts across several service systems in addition to the mental health system including education, child welfare, juvenile justice, substance use, and pediatrics. This results in a high degree of fragmentation. "Systems of care" is the conceptual framework used to address the problem of fragmentation. I discuss what it is and whether it is effective.

With regard to prevention of mental illness, I provide an overview of the of different conceptual approaches to prevention and of the theory of "adverse childhood events" (ACES). I suggest skepticism about the possibility of preventing severe mental disorders such as schizophrenia but note the effectiveness of preventive efforts focused on specific, limited goals using evidence-based interventions that are realistically possible to implement.

With regard to promotion of mental health, I discuss three different, but complementary, perspectives on what is needed to help children and adolescence achieve well-being—the theory of positive psychology, theories of psychological development, and the theory of "social determinants" of health and mental health.

This lecture ends with a child mental health policy agenda for change.

In today's lecture, I will talk about two quite different perspectives on child mental health—(1) the need for mental health and other services for children and adolescents with diagnosable emotional disturbance and their families

and (2) the responsibility of society to provide the conditions necessary for successful psychological development from conception to adulthood.

In Part One, I discuss the service needs of children and adolescents with serious emotional disturbance and of children and adolescents with mild-moderate emotional disturbance. In Part Two I discuss both prevention of mental illness and the promotion of mental health.

A critical underlying question to keep in mind during this discussion is **which of these elements of child mental health policy should be our nation's priorities.** Should prevention of mental illness and promotion of mental health have priority over treatment or vice-versa? Should treatment of children with serious emotional disturbance have priority over children with non-severe diagnosable disorders or should these populations be treated as equally important?

## PART TWO: SERVICES FOR CHILDREN AND ADOLESCENTS WITH EMOTIONAL DISTURBANCE OR SERIOUS EMOTIONAL DISTURBANCE

### Epidemiology

About **20% of children and adolescents (under 18) have a mental or substance use disorder** ("emotional disturbance")[1] and **about 10% have a "serious emotional disturbance"** (SED) [2].

**"Serious emotional disturbance"** is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a diagnosable mental disorder that results "in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities."[3] Children and adolescents with serious emotional disturbance frequently have difficulty learning in school, have limited social relationships, engage in activities in isolation, engage in socially inappropriate behavior, are very strange, have tense or violent relationships with family, come into conflict with the law, etc.

**Most** children and adolescents with emotional disturbance, even those with serious emotional disturbance **do not get appropriate treatment**.[4] In part this reflects the fact that mental disorders are often difficult to distinguish from normal emotional turmoil in adolescence and often resolve without treatment. It also reflects continuing reluctance to acknowledge psychological problems and to seek help. And very importantly, it reflects the fact that child mental health services are in exceedingly short supply and often difficult to get access to.

Children and adolescents who get treatment get it both in the public and the private sector.

In the **public sector**, mental health services are provided in the mental health, education, child welfare, juvenile justice, healthcare, substance use, and physical health care systems.

In the **private sector**, treatment is provided mostly by primary health care professionals and by mental health professionals in private practice. Some children and adolescents get treatment in private schools, both day and residential.

Fortunately, **public child mental health policy** recently has been focusing considerable attention on the treatment of emotional disturbance in primary health care. Unfortunately, it **continues to neglect** the very large role played by mental health professionals in **private practice**.

## Mental Health Services For *Serious* Emotional Disturbance

Mental health policy for children and adolescents with serious emotional disturbance has gone through a transformation similar to the transformation of services for adults with psychiatric disabilities. What was primarily an **institution-based system has become community-based**. In both the private and the public sectors, there has been a major push to **reduce the use of inpatient hospital and residential treatment services** in favor of outpatient services including day treatment as well as office-based psychotherapy and medication therapy.

It has been clear for 40 years or so that **traditional office-based services are of limited benefit for children and adolescents with SED**. Psychotherapy and medication therapy are often useful for this population; but, like adults with psychiatric disabilities, they need a broad array of services that go beyond treatment including social skills development, support in school, recreational/social opportunities, family support, case/care management, and more.

Recognition of the broad array of needs led to the development of the Federal Child and Adolescent Service System Program (CASSP)[5]—a counterpart to the Community Support Program (CSP) for adults. The core concept is that **children and adolescents with SED need a "system of care" (SOC) that provides a "comprehensive" range of services and integrates services across child serving systems including mental health, child welfare, education, juvenile justice, and more**.[6] (see attached chart)

The comprehensive array of services includes both services provided while a child/adolescent is living at home and residential services.

Mental health services that need to be available while living at home include:

- **Crisis services**, hopefully not limited to emergency rooms
- Verbal and medication **therapies**
- Educational, social, and recreational **supports**
- **Day treatment**, a therapeutic milieu that combines treatment and education
- **Family support** services such as respite.

Sometimes, it is essential to remove children/adolescents from their homes either because they are victims of abuse or neglect or because they need services that cannot be provided while they are living at home. Residential services range from less to more restrictive with a preference always for the least restrictive settings. These include:

- **Therapeutic Foster Care**
- **Group Homes**
- **Residential Treatment**, which combines milieu therapy, treatment, and school
- **Hospitals,** preferably local hospitals with special units for children and for adolescents. This can include general hospitals, private psychiatric hospitals, and state hospitals for children and adolescents.

**Case/care management** is a critical element of a comprehensive system of care. Case/care managers are often the primary source of intervention in times of crisis. Often, they also take the lead in case planning and in coordination of care.

In the system of care model, **families are regarded as partners in care** rather than as the noxious causes of their children's mental illnesses. Obviously, there are limits to this because some families are irredeemably abusive or neglectful. But in general, families are viewed as part of the system of care.

As already noted, a system of care integrates various child serving systems. In addition to mental health, this includes education, physical healthcare, education, child welfare, juvenile justice, substance use, etc. Systems of care attempt to weave these systems together into **"networks"**. Networks generally work together on three levels—case, local systems, and policy.

For example, in the mid-1990s NYS developed the Coordinated Children's Services Initiative (CCSI). In each locality, there are regular meetings of providers from various systems to deal with difficult cases that require special coordinative efforts. In addition, there is a local committee that focuses on problems in the local system and barriers that arise from state

policy. Recommendations for broad policy changes are sent to a statewide CCSI committee.

Westchester County in New York took a somewhat different and very successful approach. It developed groups called "networks" in several different communities so as to stay very local. They combined these networks of providers with parent groups in each community and included parents in the functions of the networks. In addition, they developed youth councils that consist of adolescents with serious emotional disturbance and that provide advice to the networks and to the county Department of Community Mental Health.

Despite 30 years of commitment to building systems of care, funding has remained difficult. Between 1993 and 2017, The Federal government provided 340 grants around the country to stimulate the development of systems of care. That is a bit over 10% of the 3243 counties in the United States. In addition, federal grants pay for management of the network and not for services, and the grants are time limited. Only 60% of the programs have continued after grants ended.[7,8]

Of course, many services are covered by **Medicaid**, but **only for families that are eligible** for Medicaid and only for covered services, which are mostly traditional clinical services that are of limited value for children and adolescents with serious emotional disturbance. Some additional funding is made available through the federal mental health block grant and state governments that provide funding for child mental health programs of various kinds.

To address the need for funding for non-traditional services and supports, states have developed **"home and community-based waiver"** services. The states apply to the federal government for a waiver from Medicaid rules so that they can use funds that would have been spent on inpatient services for community-based services instead. This has been a valuable source of funding for systems of care—but limited because it is not open-ended. Waivers designate a certain number of "slots" based on projected inpatient savings.

As I noted above, it appears that the use of formal systems of care for children and adolescents with serious emotional disturbance is quite limited. However, many states have instituted Medicaid managed care systems that attempt to coordinate needed care and may be providing some of the needed integration of care.

Funding for child mental health services is also available through the education, child welfare, juvenile justice, and other systems. But each

system provides funds for particular purposes and for particular programmatic approaches, and this funding also is not open-ended.

Over the years, efforts have been made to **integrate funding** from mental health, child welfare, education, and juvenile justice systems to support **"individualized care"** in which each child and family has a service plan that responds to their particular needs and preferences.[9]

One model for this is a local child and adolescent service system with a single point of planning for any needed mental health, health care, child welfare, and other services, with a single family case manager rather than managers from each system.[*]

When I was attempting to introduce this model in the mid-1990s, using it proved exceedingly difficult in part because of the rigidity of bureaucratic rules and in large part because of the rigidity of the people responsible for services in each system. It is very, very hard to get people to cooperate if the choice is theirs to make one way or the other.[**] As a result, much service for children and adolescents with SED is still fragmented among different systems.

A Double Standard? The observations above apply only to the public sector, where it is taken for granted that it is better to serve troubled children and adolescents in the community rather than in residential care. However, in the private sector—where parents pay for care—sending children and especially adolescents to special residential "schools" is commonplace and often seen as desirable.

Yes, from time-to-time private residential services come under attack for inhumane treatment of children and adolescents. And this has resulted in efforts to improve and control quality of care. But parents who can afford it are still free to send their children and adolescents to special schools just as they are free to send them to boarding school.

From my point of view, this is just another example of double standards for the affluent. But it ought to make us wonder whether the public sector's insistence on providing service in the "least restrictive setting" is ideologically sound.

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[*] It is important to distinguish this model, which provides multiple points of entry to integrated planning, from the single-point of entry model, which often results in bottle necks and long waits for service.

[**] I used to have a sign in my office. "Collaboration is an unnatural act committed by non-consenting adults." Something of an overstatement perhaps, but very much reflective of my experience trying to develop systems of care.

## Mental Health Services For Non-Sed Children And Adolescents

Historically, the child mental health system has given priority to children and adolescents with serious emotional disturbance. But, as previously discussed, the availability of funding for community mental health and the advent of Medicaid resulted in vastly expanded publicly funded mental health services for children and adolescents without SED.

Although there is still a dispute about which populations should get priority in the public mental health system, in fact the system addresses the needs of both those with SED and of those less severe emotional disturbance who cannot afford care in the private sector.

Publicly supported services for those with less severe mental health problems are also available in schools, child welfare programs, community health centers, juvenile justice facilities, etc.

And, there is a significant private sector of treatment, which is covered by health insurance or paid for by parents hoping to get help for their children and themselves.

### Treatment for non-SED children and adolescents in the public mental health system

Mental health services for non-SED children and adolescents in the public mental health system are provided almost entirely at **traditional child mental health clinics**. These facilities provide office-based verbal and medication therapies after first doing an assessment, developing a diagnosis, and establishing a treatment plan. Clinics **provide individual, group, and family therapy** usually once a week for 30-50 minutes.

Some clinics are owned and operated by governmental entities, others by non-profit or for-profit hospitals, others by non-profit or for-profit community agencies, others by training institutes, and still others by groups of private practitioners.

**Clinics are licensed by the states**. **Some**—especially the hospital-based clinics—**are also accredited by the Joint Commission.**

**Clinics have significant limits** that raise questions about how valuable they are for children and adolescents and their families.

They are **often unable to respond to crises** of the kinds that motivate people to ask for help. Instead, there are often waiting lists for evaluation and then substantial waits to begin treatment. In addition, clinics often do

not provide an adequate response to their patients/clients who experience crises outside their scheduled appointment. Some have no more than an answering machine that refers emergency callers to 911.

Required processes of assessment and diagnosis often delay engagement in treatment. As a result, **most people who ask for help do not return for more than 3 visits**, often fewer.

**Once a week visits of an hour or less are often not sufficient** for people who are struggling with what they experience as a crisis in their lives. Unfortunately, the nature of funding creates a barrier to providing multiple and/or lengthy sessions when needed.

Clinics usually are open 9-5 Monday through Friday with evening hours a couple of days a week. They are generally not open on weekends. These **limited office hours** are often not workable for children and adolescents in school and after-school activities or for their parents, who may be working when the clinic is open.

**Few clinics provide home and community visits**, which are often necessary for people who face serious transportation problems or who just can't face the stigma of going to a mental health program. This problem has been ameliorated to some extent by the use of **telehealth**. Hopefully this will continue after the pandemic emergency period is declared over.

Although a majority of clinic staff are usually experienced clinicians, most **rely on recent graduates and students** to fill out their staff.*

Recognition of some of these problems has led to the development of some **school-based clinics**. Some clinics also operate **satellites in community settings**. School-based programs, unfortunately, usually operate on the same schedule as the schools, i.e., 180 days per year. Mental health problems exist 365 days a year.

Efforts have been made to change regulations and funding structures to make clinics more responsive to the populations they are supposed to serve. For example, in some states, clinics are required to see people asking for help within a few days. But requirements of this sort haven't gone very far,

* In NYS this has led to a political battle between clinical social workers and state government. For years, NASW of New York and other groups have advocated for clinics and other programs to use primarily licensed clinical social workers so as to enhance quality. NYS government and many agency administrators, which are concerned about whether enough staff will be available to meet the need for services, have advocated for the use of less qualified staff so as to respond to widespread need.

and it's safe to say, that significant change is unlikely as long as clinics are filled to capacity—as most are.

## Treatment for non-SED children and adolescents outside the mental health system

As already noted, mental health services for children and adolescents are also provided by primary healthcare providers, schools, child welfare programs, etc.

Pediatric Medical Care is a common starting point for parents concerned about their children's mental health. Unfortunately, pediatricians and other primary healthcare providers are rarely well-educated regarding mental health issues.[10] **Most do not routinely screen for mental or substance use disorders.** When they provide treatment, they **rely heavily on medications** and probably over-use them. But given the amount of time that a pediatrician can devote to a patient visit, it is unlikely that they can themselves provide verbal therapy for the child and/or parent(s).

**Patient-Centered Medical Homes**[11], a concept developed by pediatricians, should address some of the shortcomings of pediatricians in private practice. These medical groups are supposed to do routine screenings and have the capacity to provide diagnosis and treatment, either directly or via formal linkages with mental health providers.

Increasingly pediatric practices are being seen as the primary point of identification and intervention for mental health issues in children and adolescents as well as adults. As a result, **community health centers are emerging as major providers** of mental health services[12], sometimes with licenses as mental health clinics, sometimes not.

Schools are a major source of treatment for children and adolescents with emotional disturbance.[13] Many schools have social workers, counselors, and psychologists on staff to help children and adolescents who are experiencing difficulty in school. It is important to note that most educators do not believe that it is their job to identify and intervene with students with emotional problems unless these problems affect their learning or behavior in school. When they do notice problems that do not affect the school experience, they generally refer out to public or private mental health providers.

Schools also have an obligation under the Individuals with Disabilities Education Act (**IDEA**)[14] to provide special education and "related" services to

students with disabilities. **Related services**[15] include treatment for "serious emotional disturbance".*

The process through which schools determine what services they must provide is often long, complicated, and hugely frustrating for parents. There must be a comprehensive assessment and then an individualized education and services plan that must be reviewed and approved by the school's special education committee.

The education and services plan is supposed to emphasize **"mainstreaming" or "inclusion"**[16] rather than placement in special classes in special settings or in residential schools. This ideological base for special education is highly controversial. Many parents and teachers are troubled about the extent to which the inclusion of students with special education needs, especially those with behavior problems, distracts from the education of students without special needs.

The Child Welfare system[17] serves children and adolescents whose parents **abuse or neglect** them. The system has four major functions:

1. Investigation of allegations of abuse or neglect and taking appropriate protective action, including removal of the child from the home if necessary to assure safety. ("**Protective services**")

2. Provision of, or payment for, services that will prevent placement out of the home. ("**Preventive services**").**

3. **Placement out of the home** in foster boarding homes, group homes, or institutions (some of which provide residential treatment). The goal of these services is either reunification with the family of origin or adoption.

4. **Transitional supports** for adolescents who become young adults while in out-of-home placement.

Not surprisingly, a very large portion of children and adolescents served by the child welfare system have emotional problems, and **child welfare agencies provide mental health services** to try to help them. Some agencies provide these services directly; some provide them via referral to mental health providers.

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* "Serious emotional disturbance" is defined differently in the education and mental health systems.

** "Preventive services" is defined differently in the child welfare and mental health systems. In child welfare it means prevention of placement out of the home. In mental health it usually means prevention of emotional disturbance

In addition, the parents of children and adolescents in the child welfare system often have significant mental and/or substance use disorders, which may or may not be addressed by child welfare programs.

That said, it is important to be clear that **being mentally ill does not necessarily result in inadequate parenting**. This has been a matter of controversy in public policy regarding whether parental mental illness by itself is grounds for removal from the home.

The Juvenile Justice system[18] has historically been responsible for children and adolescents who commit crimes or actions that would be crimes if they were adults. It has also been responsible for children and adolescents in need of supervision because their parents are unable to control their inappropriate behavior such as truanting, disturbing the community, inappropriate sexual behavior, behavioral disrespect for parents and other adults, etc. These are actions that would not be crimes if they were adults ("status offenses").

Prior to the 3rd quarter of the 20th century, children and adolescence adjudicated as juvenile delinquents or persons in need of supervision were very often removed from their homes and placed in residential facilities including detention centers, reform schools, residential treatment centers, etc.

Later the emphasis of the juvenile justice system—like the mental health and child welfare systems—focused on prevention of placement out of the home and the provision of services in community programs. This included mental health services provided either directly or by referral.

Although it is not exactly a mental health issue, it is important to note that until very recently there has been an active debate about whether and **when to treat children and adolescents who commit crimes as adults** subject to the same lengthy prison sentences as adults.

**Hard to integrate**: I hope these little descriptions of pediatric, education, child welfare, and juvenile justice systems make it clear that each has a different purpose as well as different rules and procedures. It is little wonder why integration has been so hard to achieve.

## Treatment for Non-SED Children and Families In The Private Sector

As previously noted, many children and adolescents and their families get mental health services through the private sector, which they rely on both to provide and pay for needed services.

It is very important to keep in mind that most people get mental health coverage through employer-based health insurance. Increasingly that is a standard benefit of health plans, but there are still significant choices left open to employers. So, **what should be mandated in employer-based plans is a significant policy issue**.

Insurance generally is used to pay for services provided by private practitioners. Although they must be licensed, many parents worry about finding providers who are really good. **Should there be a system for rating private practitioners?**

Many people also find it difficult to locate a private practitioner. Public information and referral systems generally do not refer to providers in private practice. There are private referral systems online, but how effective they are in helping families to find someone who will be good for them is an important question.

Insurance also covers treatment in private psychiatric hospitals. Usually this is time-limited, especially if it is being paid for by insurance companies that use behavioral managed care (probably all of them). Whether managed care companies effectively assure access to medically necessary treatment while preventing unnecessary, and expensive, treatment out-of-the-home is, I believe, still an open question.

Some parents, who are at wit's end and who can afford it, decide to send their children and adolescents to private schools for emotionally disturbed children and adolescents or to residential treatment or to drug rehabilitation programs or to tough love experiences such as survival camps, etc. These programs seem to be effective for some children and adolescents, but they come under attack from time-to-time when there is a revelation of an inhumane practice or when there is dreadful outcome such as the death of a run-away.

All this suggests that there may not be adequate access to, or quality control of, private providers, raising several important questions:

- Should behavioral health be a mandated component of private health insurance?
- Should public information and referral services refer to private practitioners and programs?
- Is professional licensing sufficient to assure minimally adequate care?
- Should there be more thorough review when licenses are renewed?
- Should managed care companies be subject to quality standards?

## PART TWO: PREVENTION OF MENTAL ILLNESS AND PROMOTION OF MENTAL HEALTH

Discussions of prevention often neglect the very important distinction between prevention and promotion. Prevention is about reducing the incidence and/or prevalence of mental illness or of the common consequences of mental illness. Promotion is about helping people to be mentally healthy. We prevent mental illness; we promote mental health.

### Prevention

Prevention of mental illness by improving childhood experiences and environmental circumstances has long been a hope of health and mental health professionals. For example, 60 years ago community education was included as an essential element of community mental health centers[19] because it was believed that this would reduce the prevalence of serious mental illness. And over a century ago improving child rearing was the major goal of the child study movement.[20]

Sadly, efforts to prevent serious mental disorders have been unsuccessful. Fortunately, efforts to achieve some other goals of prevention have been somewhat successful. Most notably this includes reducing the number of children and adolescents who are placed in institutions and/or excluded from school.

Recently, there has been a resurgence of hope regarding prevention of mental illness because research done over the past two or three decades appears to provide insights into the causes of problems in later life. [21,22]

The most frequently noted studies are about "**adverse childhood experiences**" (ACEs). These studies indicate that abuse, neglect, and "household challenges" such as drug abuse, domestic violence, and severe parental mental illness contribute to mental illness, substance use disorders, criminal activity, physical illness, disability, and premature death.[23]

In addition, many studies have led to the identification of environmental conditions that contribute to poor physical and mental health outcomes. Called "**social determinants**" of health and mental health,* these factors include poverty, violence, racism, unsafe housing, poor education, etc.

I have speculated that the mental health of adolescents and young adults may be negatively affected by "**adverse world events**"[24]—by the murder of

* Recently, it has been suggested that the term "social determinants" be replaced with "social drivers" as a way of indicating that these factors may contribute to certain outcomes but they don't inevitably cause them.

Black people at the hands of police and other hate crimes, by the rising number of mass murders, by climate change, by vituperative political divisions, by the specter of nuclear holocaust, by the increasing numbers of refugees living in terrible conditions around the world, and so forth. Even paying cursory attention to the daily news takes a significant emotional toll.

The key question, of course, is how to intervene so as to reduce risks of poor outcomes in childhood, adolescence, and adulthood. How can we reduce adverse childhood experiences, especially severe problems within the family? How can we temper social determinants of physical and mental illness such as poverty, community violence, and racism? Can we reduce the impact of adverse world events such as the pandemic and horrors of all kinds that are featured in the news daily? Is it realistic to expect mental health professionals and advocates to pursue progressive social policies in order to improve the chances of good outcomes in life?

Fortunately, there are forms of preventive intervention that are less ambitious and more doable in the real world. These include interventions to reduce the likelihood that teenagers will commit crimes, misuse drugs, or become pregnant. It includes interventions to improve perinatal care, interventions to improve parenting, and interventions to reduce family violence. It includes improved screening in pediatric care and in day care and schools. It includes provisions for early intervention. It includes early childhood programs,* social skill development, etc.

My personal favorite is the **Nurse-Family Partnership** model, which is used universally in the Scandinavian countries and used selectively for families at risk of abuse or neglect in some parts of the United States. [25,26,27] This is a program in which a public health nurse or other professional visits a pregnant woman and her family before she gives birth to encourage pre-natal care and to help prepare for parenthood. The nurse also visits the family after birth to help them master the tasks of parenting.

It appears to be a highly effective program, but it raises two key policy questions. First, **should the government routinely intervene in the home life of families,** even those thought to be at risk of abuse or neglect, or is that a purely private matter until abuse or neglect actually takes place? Second, **should this be a universal program** serving all pregnant women as in Scandinavia or a program targeted to women identified as at high risk of abuse or neglect as in the United States?

* The recent "discoveries" regarding adverse childhood events have fueled a growing emphasis on "**early childhood mental health**", which is sometimes defined as 0-3, sometimes 0-5, and sometimes 0-8. Whatever the age range, the fundamental insight is that early childhood is a period of rapid and critical developmental changes and that developmental failures at a very young age can have a devastating effect later in life.

Conceptual Frameworks For Prevention:

Historically, there have been a number of different conceptual frameworks for prevention.

During the early days of the community mental health movement, preventive interventions were regarded as "primary", "secondary", or "tertiary". Although this framework is out of date, I find it very useful.

Primary means either (1) preventing the development of a problematic health condition such as the use of vaccines to eliminate smallpox and/or (2) substantially reducing the prevalence or incidence of a health condition such as the vaccine for the flu.

Secondary prevention means early intervention. For example, getting treatment fast if you have symptoms of a heart attack. The longer you wait the more likely you are to suffer disability or death.

Tertiary prevention means preventing the disabling consequences of an illness or injury. For example, getting physical therapy after spinal surgery can promote rapid recovery of function.

More recently, a framework has been developed that sees prevention as part of a continuum of care from promotion to maintenance of health. [28] This framework distinguishes between "universal", "selective", and 'indicated" preventive interventions, which are explained below in material taken from *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*. [29]

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**Definitions of Promotion and Prevention Interventions**

***Mental health promotion* interventions:** Usually targeted to the general public or a whole population. Interventions aim to enhance individuals' ability to achieve developmentally appropriate tasks (competence) and a positive sense of self-esteem, mastery, well-being, and social inclusion, and strengthen their ability to cope with adversity.

**Example:** Programs based in schools, community centers, or other community-based settings that promote emotional and social competence through activities emphasizing self-control and problem solving.

***Universal preventive interventions:*** Targeted to the general public or a whole population that has not been identified on the basis of individual risk. The intervention is desirable for everyone in that group. Universal interventions have advantages when their costs per individual are low, the

intervention is effective and acceptable to the population, and there is a low risk from the intervention.

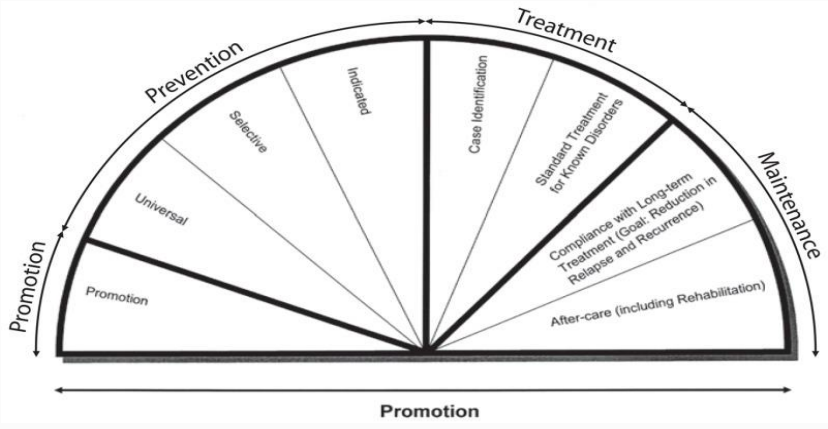
**Example:** School-based programs offered to all children to teach social and emotional skills or to avoid substance abuse. Programs offered to all parents of sixth graders to provide them with skills to communicate to their children about resisting substance use.

***Selective preventive interventions:*** Targeted to individuals or a population subgroup whose risk of developing mental disorders is significantly higher than average. The risk may be imminent, or it may be a lifetime risk. Risk groups may be identified on the basis of biological, psychological, or social risk factors that are known to be associated with the onset of a mental, emotional, or behavioral disorder. Selective interventions are most appropriate if their cost is moderate and if the risk of negative effects is minimal or nonexistent.

**Example:** Programs offered to children exposed to risk factors, such as parental divorce, parental mental illness, death of a close relative, or abuse, to reduce risk for adverse mental, emotional, and behavioral outcomes.

***Indicated preventive interventions:*** Targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental, emotional, or behavioral disorder, or biological markers indicating predisposition for such a disorder, but who do not meet diagnostic levels at the current time. Indicated interventions might be reasonable even if intervention costs are high and even if the intervention entails some risk.

**Example:** Interventions for children with early problems of aggression or elevated symptoms of depression or anxiety.



My own view on prevention is considerably simpler. It may be excessively simple, but when I am involved in discussions about prevention, I ask four questions.

- What specifically do we want to prevent?
- How specifically will we do that?
- What reason is there to believe that the intervention will work?
- Can the intervention be instituted widely enough to have a significant impact on the population we want to help?

For example:

- Goal: Eliminate, or reduce the prevalence of, schizophrenia.

- Intervention: Provide widespread early childhood parent education.

- Rationale: Schizophrenia is caused by maternal behavior 0-3.

- Widespread impact: Mandate public education of parents.

This proposal is clear, but it has fatal flaws, most importantly **the rationale is empirically incorrect**.

In contrast, here's an intervention that has been somewhat effective.

- Goal: Reduce average length of stay of placements out of the home for children or adolescents with serious emotional disturbance

- Intervention: Create a system that combines

    - providing services to help parents and their children
    - administrative and judicial reviews of decisions of retaining children in out-of-home placements

- Rationale: Many children could remain in their homes if they and their parents got treatment and support services. And many placements reflect uninformed decisions. A process of review will reduce this.

- Widespread impact: Services to reduce out-of-home placement and administrative and judicial reviews can be built into the existing child welfare system.

There have been many evaluations of these kinds of preventive interventions that show that they are effective at least to some extent.[30]

I would add that evaluations to check on outcomes are an important contributor to program success because they keep providers on their toes and because they make it possible to remodel or abandon programs that are not succeeding.

To repeat, although there are good reasons to be skeptical regarding prevention of mental illness, there are reasons for optimism about preventive interventions that (1) are **specific about goals**, (2)use **a form of intervention that is specific and credible**, and (3) can realistically **move beyond a demonstration project** to widespread use.

## Mental Health Promotion: Nurturing Children and Adolescents

As I noted earlier, prevention and promotion are not the same thing. Mental health promotion reflects the responsibility of society to help children grow and develop into adults who will in their time contribute to the growth and development of the younger generation.

How can the field of mental health contribute to this? Obviously by providing effective care and treatment for children and adolescents with mental health problems. But what else? What can our field do to nurture the development of children and adolescents and help them thrive?

There are three perspectives to bring to bear on mental health promotion:

- Positive Psychology
- Lifespan/Psychological Development
- Social Determinants of Mental Health

### Positive Psychology

The field of positive psychology distinguishes between (1) "negative" psychology, which is about mental illness and other psychological problems, and (2) "positive" psychology which is about the psychological conditions of human "well-being", which is a multi-dimensional state that includes safety, health, adequate material conditions, social connections, satisfying activity, pleasure, love, a sense of meaningfulness, etc.

Martin Seligman, the so-called "father of positive psychology" identifies five broad areas of psychological well-being: positive emotion (happiness), satisfying social relationships, engaging activity, accomplishment, and meaning.[31]

More simply said, children need loving family relationships, friends, activities that interest them, education, opportunities to take on adult roles when the

time comes, a sense of belonging, a sense of purpose, and—for many—a spiritual sense of connection with a divine universe.

There are a number of programs that have been developed to promote psychological well-being during childhood and adolescence. For example, a program called "positive education" is now in use in some schools.[32]

Lifespan/Development

The lifespan/developmental perspective notes that people develop from birth to death through a series of stages, each of which has challenges that can be met more or less successfully.[33]

Psychological well-being is different in each state of development.

According to the CDC, the stages of child development are infants (0-1), toddlers (1-2), toddlers (2-3), preschoolers (3-5), middle childhood (6-8), middle childhood (9-11), young teens (12-14), and teenagers (15-17). [34]

CDC's choice to end childhood at 17 reflects the meaning of "child" in public policy. You can vote at 18. But it is not good psychology. Adolescence does not end at 17. Functionally it continues until a person has to make a transition to behaving like an adult.

The CDC framework is also questionable with regard to the first phase of development. The recent study by the National Academies of Science, Engineering, and Medicine (NASEM)[35] adds the peri-natal period to these stages and maintains that, from the standpoint of mental health promotion, the pre-conception phase is also important to the developing fetus and to expectant mothers, especially pregnant teenagers.

Despite minor differences regarding exactly what the stages of child development are, it is clear that over the course of childhood, children will usually develop different psychological strengths at different times including: attachment, affection, mastery of skills, peer relationships, cognitive capacities, individuation, preparation for work and/or parenting, responsibility, compassion, ethical self-expectation, positive self-regard, community connection, and, for many, spirituality. Helping this to happen is a critical element of mental health promotion.

Social Determinants of Mental Health

The concept of "social determinants" refers to social factors that contribute to the development of physical and/or mental health conditions. Usually, they are identified as the factors that contribute to problematic conditions—family and community violence, poverty, racism, poor education, pandemics,

war, dislocation, etc. But for purposes of health and mental health promotion, it is important to also identify the social factors (sometimes called "protective factors") that contribute to good health and mental health—safety, adequate income, decent housing, good schools, good health care, non-discrimination, membership in a community, etc.

There is no doubt that improvements in social circumstances for disadvantaged populations could vastly improve their psychological outcomes. How realistic it is for the field of mental health to take on the big social issues of our time is a critical question. Can mental health practitioners and policy makers realistically pursue both meeting the needs of the individuals and families in distress and progressive social policies? Should there be an expectation that they do so?

Implications for Mental Health Promotion

It seems to me that mental health promotion efforts need to be derived from an amalgam of positive psychology's goal of well-being, for different developmental phases, with a heavy emphasis on addressing social factors. And I believe that there are steps short of social revolution that we can take to improve the environmental circumstances of children. But there are significant challenges to doing so.

Some current challenges

At this moment in American history there are several troubling new challenges to the mental health of children and adolescents, particularly the psychological fallout of the pandemic, the impact of social media, and the impact of exposure to "adverse world events".

The pandemic resulted in great dislocation in the lives of children and adolescents [36], especially those who live in families in which economic survival has been a struggle, who have not been able to attend school, who have been cut off from friends, who have experienced increases in family violence in their homes, and who have parents in emotional distress who increasingly misuse alcohol and drugs[37].

Frequently, mental health professionals and others point to the need for access to mental health services during the pandemic, and there is no doubt that there has been an increase in demand for services.[38] Tele-health has made it possible to respond to requests for help even when in-person contact is not safe.[39]

But it may well be that what are most valuable for children and adolescents in the pandemic are the vaccination program that reduces the spread of COVID, the economic relief efforts that have protected children and families

from homelessness and starvation, public health measures that make it possible to manage the dangers of contagion, and the re-opening of community programs like team sports and houses of worship.

There is much speculation that children will suffer long-term psychological damage because of the pandemic. I am sure that some children will experience long-term problems, but I am not at all sure how widespread it will be. It seems possible to me that there will be more resilience than persistent psychological distress.[40] I will discuss this in a couple of weeks in my lecture about the pandemic.

The psychological impact of the social media[41] is another major issue of the moment. Adolescent depression and suicide are on the rise, and many pundits and professionals have linked this to the rise of social media.

I have reservations about blaming declining mental health on social media. Yes, there are many examples of cyber bullying, social exclusion, body shaming, etc. But a majority of adolescents and young adults, when asked, identify relationships online as a major source of support when they are struggling with bad feelings.[42]

And from a policy perspective, balancing the effort to protect children from noxious influences while avoiding censorship that violates the right to freedom of speech will be a very difficult challenge.

I am inclined to believe that exposure to adverse world events and vituperative political divisions are also contributing to the apparent increase in adolescent depression. For example, in the week after George Floyd was murdered by a police officer, symptoms of emotional distress rose substantially, especially for Black people.[43] And in a survey a couple of years ago in which young people were asked what caused distress, many answered that it was the events they saw in the news.[44]

## A CHILD BEHAVIORAL HEALTH ADVOCACY AGENDA

Although there has clearly been significant progress in addressing the behavioral health issues of children and adolescents and their families, there is much left to be done. The following is a tentative agenda for policy change that draws from the goals of various advocacy groups.

1. Develop a **National Child Mental Health Plan** covering prevention of mental illness and promotion of mental health as well as service provision for those with diagnosable emotional disturbance, serious emotional disturbance, or substance use disorders. Require states to develop similar plans

2. Increase the nation's **capacity** to provide competent behavioral health services

   - Address workforce shortages
   - Provide adequate funding for service programs

3. Increase **access** to services for those with diagnosable conditions

   - Address problem of cost with universal mental health coverage
   - Address problems of the location of services
   - Expand behavioral health services in schools
   - Address the problem of limited service hours
   - Increase linguistic and cultural competence
   - **Allow and support tele-behavioral health services**

4. Improve **quality of care**

   - Improve crisis services
   - Remodel clinics
   - Explore alternatives to inpatient care in hospitals
   - Enhance clinical, cultural, and generational competence
   - Increase collaborative care management in primary care practices

5. **Integrate service systems**: behavioral health, medical care, education, child welfare, and juvenile justice

   - Expand use of system of care model
   - Support care integration via Medicaid managed care

6. **Pursue regulatory reform** and structural changes in funding so as **to support non-traditional mental health service** provision.

7. Reduce the **bureaucracy of special education**

8. Improve **child welfare and juvenile justice services**

9. Increase efforts to **promote mental health and prevent mental illness**

   - Provide additional funding for evidence-based preventive interventions and measures to promote mental well-being*

* One bright note is that Medicaid provides funding for early, periodic screening, diagnosis, and treatment (EPSDT). In essence, this makes it possible for children from families who are eligible for Medicaid to get the kind of early care that medically affluent families take for granted, such as regular visits to pediatricians to check developmental progress and access to specialists to address developmental delays.

- Increase research regarding prevention and promotion

- Pursue social changes that will contribute to well-being and will reduce the prevalence/incidence of behavioral health problems

    - Take steps to reduce adverse childhood experiences
    - Address social determinants of poor mental health and to increase social determinants of good mental health including:

        - Adequate income supports
        - Stable housing
        - Measures to reduce family and community violence
        - Family support
        - Measures to promote equity in education
        - Measures to reduce racism in the health and behavioral health systems

10. Address current critical concerns:

    - Psychological fallout of the pandemic
    - Suicide [45]
    - Drug overdoses
    - Impact of social and other media on child and adolescent mental health.

Daunting, no doubt! More than enough to fill the years of work ahead for your generation.

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[1] CDC (retrieved 2021). "Improving Access To Children's Mental Health Care"

[2] Williams, N. et al (2018) Prevalence of Serious Emotional Disturbance Among U.S. Children: A Meta-Analysis - PubMed (nih.gov)

[3] SAMHSA (2014). "Summary of Panel Discussions and Recommendations, Serious Emotional Disturbance (SED) Expert Panel Meetings, September 8 and November 12, 2014

[4] CDC (retrieved 2021). "Improving Access To Children's Mental Health Care"

[5] Child and Adolescent Service System Program (CASSP) (ny.gov)

[6] Stroul, B.A., Blau, G.M., & Larsen, J. (2021). The Evolution of the System of Care Approach. Baltimore: The Institute for Innovation and Implementation, School of Social Work, University of Maryland.

[7] The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program. 2017 Report to Congress (samhsa.gov)

[8] Beyond_Systems_of_Care.pdf (michaelbfriedman.com)

[9] Friedman, R and Drews, D (2005). *Evidence-Based Practice, Systems of Care, & Individualized Care*. Louis de la Parte Florida Mental Health Institute University of South Florida

[10] Mental Health Competencies for Pediatric Practice (silverchair.com)

[11] Defining the PCMH | Agency for Healthcare Research and Quality (ahrq.gov)

[12] Behavioral Health - NACHC

[13] Press Release - Roughly Half of Public Schools Report That They Can Effectively Provide Mental Health Services to All Students in Need - May 31, 2022

[14] Individuals with Disabilities Education Act (ACT) (apa.org)

[15] Sec. 300.34 Related services - Individuals with Disabilities Education Act

[16] Francisco, M. et al (2020). "Inclusion and Special Education" in *Education Sciences*,

[17] Child welfare - New World Encyclopedia

[18] What Is Juvenile Justice? - The Annie E. Casey Foundation (aecf.org)

[19] Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963 | American Journal of Psychiatry Residents' Journal (psychiatryonline.org)

[20] Child Study | Encyclopedia.com

[21] NASEM (2009) Preventing Mental, Emotional, and Behavioral Disorders Among Young People - NCBI Bookshelf (nih.gov)

[22] NASEM (2019) Fostering Healthy Mental, Emotional, and Behavioral Development among Children and Youth | National Academies

[23] Adverse Childhood Experiences (ACEs) (cdc.gov)

[24] Friedman, MB (2019). "To Improve Adolescent Mental Health We May Need To Address Adverse World Events" in *Behavioral Health News*, Winter 2019

[25] http://www.nursefamilypartnership.org/

[26] https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview

[27] https://www.acf.hhs.gov/sites/default/files/opre/mihope_report_to_congress_final.pdf

[28] SAMHSA. Prevention of Substance Abuse and Mental Illness. https://www.samhsa.gov/prevention

[29] O'Connell, ME et al (2009) "The Scope of Prevention", Chapter 3 in *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. The National Research Council and Institute of Medicine.

[30] Results of Evaluations of Child Abuse Prevention Programs - Child Welfare Information Gateway

[31] Seligman, M. (2011). *Flourish.* The Free Press.

[32] What is Positive Education, and How Can We Apply It? (+PDF) (positivepsychology.com)

[33] Erikson, E. (1950). *Childhood and Society*.

[34] CDC. Child Development Tips for Parents. Positive Parenting Tips | CDC

[35] NASEM (2019) Fostering Healthy Mental, Emotional, and Behavioral Development among Children and Youth | National Academies

[36] U.S. Surgeon General Issues Advisory on Youth Mental Health Crisis Further Exposed by COVID-19 Pandemic | HHS.gov

[37] Substance use during the pandemic (apa.org)

[38] TrendWatch: The Impacts of the COVID-19 Pandemic on Behavioral Health | AHA

[39] Comparing efficacy of telehealth to in-person mental health care in intensive-treatment-seeking adults - ScienceDirect

[40] Growing_Up_During_The_Pandemic--Trauma_and_Resilience.pdf (michaelbfriedman.com)

[41] Teens and social media use: What's the impact? - Mayo Clinic

[42] Social media use can be positive for mental health and well-being | News | Harvard T.H. Chan School of Public Health

[43] The emotional and mental health impact of the murder of George Floyd on the US population | PNAS

[44] Adverse_World_Events_Print_Friendly.pdf (michaelbfriedman.com)

[45] U.S Department of Health and Human Services. *2012 Strategies for Suicide Prevention.* Goals and Objectives for Action (hhs.gov)