Current Trends in the Community Treatment of Seriously Emotionally Disturbed Youths

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It is a pleasure to initiate this column on child and adolescent psychiatry. Psychiatrists and other mental health care professionals who work with children and adolescents have needed a forum for discussing issues related to community practice—in particular, for bringing innovations in community programs for youths into our professional dialogue. Through federal and private grants, programs have emerged that have realized the ideals of the original initiatives of the Child and Adolescent Service System Program (CASSP) for the community treatment of youths (1). These initiatives promote CASSP values and principles—that is, that care should be family centered, child focused, culturally competent, community based, and integrated.

This system-of-care reform movement has been greatly advanced by The Children's Mental Health Initiatives Grants from the Center for Mental Health Services. These grants have created laboratories for experimenting with ever more effective ways of addressing the needs of our most challenging young people. Many of these programs address the fragmentation of services in poorly conceived systems of care.

I hope this column will be a forum for those who have experience in integrating mental health services for children and adolescents with social services, juvenile justice programs, schools, child and adolescent medical services, and recreational programs for youths. I also hope the column can provide a forum for discussing ways that psychiatrists and other professionals can better ally with the consumers in the system of care for youths, including parents and older youths. Supporting families who care for challenging youths requires an understanding of culture and diversity in our communities. I am particularly eager to see this column become a forum for discussing how cultural competence is achieved in serving children and adolescents.

Central to a discussion of system-of-care reform in child and adolescent services is the issue of individualized care for children and adolescents. A way to address the strengths and needs of youths has been termed the wraparound process. Innovators such as Karl Dennis, John Vandenberg, Vera Pena, and others have pioneered wraparound concepts over the past three decades (2–5). They have demonstrated that they could successfully maintain most youths in their communities by first focusing on the strengths the youths displayed and then addressing their specific needs. Most of this work has been done outside of psychiatry and outside of academic centers.

The grant programs have created a vast amount of data on the effectiveness of the wraparound process. Research on these programs is ongoing. More specific programs, including multisystemic therapy for adjudicated youths (6) and multidimensional family therapy for substance abusers (7), have proven efficacy. These programs adhere to the core values and principles of the CASSP and share many features with wraparound concepts.

In this first column I discuss the principles of a wraparound process and illustrate them by citing a program with which I am familiar.

Principles of the wraparound process

The central principle behind the wraparound process is that all children have strengths. Mobilizing and supporting a child's strengths is the surest way to support that child through difficult times. The strength-based approach in child and adolescent psychiatry is related to psychosocial rehabilitation concepts, which inform many adult mental health programs. The approach rests on sound developmental principles that are familiar to child and adolescent psychiatrists. Recovery from emotional disorders occurs most completely when a child can master the challenges appropriate to his or her developmental status.

A second principle is that care for troubled children and adolescents needs to be set in the context of their community and culture. Youths will respond to treatment more comprehensively if they are living with their family—or if they are given a more normative family setting in which to live—and if the family is a full partner in the care of the young person with problems.

Child and family teams

The wraparound vehicle for ensuring full family partnership is the child and family team. These teams are de-

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signed to respect the primary role of the family in determining the care offered to the child or adolescent. The child and family team identifies the child's strengths and specific needs. Ideally, the team determines the nature of the care to be offered to the child, purchases this care, and seeks professional consultation in making such determinations. Crucial to a wraparound process is a network of family advocates who can help a family build a viable and empowered relationship with the professionals who serve their child or adolescent.

As the wraparound process begins, the parent is encouraged to ask other family members or friends to join the team. Often this step requires family advocates to help reconnect parents with members of their extended family and with friends who have become estranged by the presence of a difficult child. Neighbors, workmates, a minister, a coach, or others in the community may be asked to join the team. Family advocates who have experienced similar problems as parents are crucial members of the team. They are chosen because they have had successes in relating to a range of service providers in a fragmented service system.

Many families who enter this process may have had relationships with a particularly helpful professional, such as a counselor, a teacher, or a social service worker. Families may ask such professionals to join the team. However, the model dictates that the proportion of professionals on the team should be no more than 50 percent. A professional care manager is assigned to the child and family team.

Often parents who enter a wraparound process are exhausted, are chronically in crisis, and want only more help from accommodating professionals. The family, the family advocate, and the care manager develop and initiate a crisis plan. The parents are persuaded to see, through a current crisis, how professionals cannot fully address the child's and the family's needs. Thus the family is empowered to assume responsibility for putting together its own support network (8).

As this process unfolds, the team begins the task of defining the young person's strengths and ways of supporting these strengths. It is the goal of a wraparound process to foster integration of the child or adolescent into his or her community in the most normative way possible. For example, if a child has a talent for playing basketball but has been unable to sustain membership on a team because of behavioral problems, a child and family team can bargain with the coach to take the child in exchange for addressing the coach's needs. An adult from the community who has been identified by the child and family team, or perhaps a paid child care worker, may accompany the child to practices and games and be available to take the child aside when necessary. That person may provide the coach with the benefit of having another adult present who can function as an informal assistant. Similarly, child and family teams will devise ways to support a child or adolescent in school and seek opportunities for the youth to form and enjoy normative peer relationships. "Practical accommodations" is the byword for the wraparound process.

A sample program

In King County, Washington, mental health, social service, and education authorities have collaborated in pooling funds for serving the county's most disturbed youths through the King County Blended Funding Project. Children are selected if they require high levels of mental health services and excessive expenditures for out-of-home placements and if they have not met with success in conventional services. These children are constantly in crisis and have been high users of hospitals and juvenile justice facilities.

As the families of these children and adolescents are admitted to the Blended Funding Project, their first contact is with a family advocate who explains the program to them, including the need to quickly build a child and family team. The team then serves as a purchaser of services by drawing from the pooled funds. Most parents have dealt with service providers who have had an agenda for the child and family that may or may not have been congruent with the family's notion of what is helpful. The team supports the parent in taking ownership of the care plan and insisting that it be consistent across agencies. The team ensures that the family can hold professionals and their agencies accountable for their work with the child or adolescent and replace providers who fail to understand and meet the needs as defined by the child and family team.

Problems in implementing effective programs

Problems in implementing this model are multiple. Some children who are involved with many systems over many years have lost their families. Some families have been separated from the child by child protective services. Other parents have severe problems of their own and have no community support at all. In such cases, child and family teams often become primarily professional teams. At times a foster parent becomes the identified parent and prefers to use professionals rather than involve his or her own family or system of support. In such families, family advocates may play a crucial role in helping the child reconnect to the community. Teams must reflect what the family believes is necessary. The model must be flexible to accommodate this most basic principle. Teams may grow and evolve over time, becoming more adherent to the model.

Despite disappointing initial evaluations (9) of programs using a wraparound approach, the data collected by the Center for Mental Health Services look promising (10,11). The critical question when studying such programs is what to measure. Certainly parents experience satisfaction as well as measurable improvements in empowerment. The King County Blended Funding Project initiated a measure of community connections and found significant improvements in the integration of families and children into their communities (12).

However, specific measures of the clinical status of children in our program did not show significant improvements, as was the case in Bickman's (9) research. Current thinking is that the assessment tools used—the Child and Adolescent Functioning

Assessment Scale and the Child Behavior Checklist—were not sensitive enough to measure changes in the functioning of very disturbed youths. Psychopathology may be fixed, as is the case with brain damage secondary to fetal alcohol exposure, limiting change and thus making family empowerment, community connections, and the meeting of needs more significant measures of outcome (13,14).

The wraparound process is fast becoming a best practice in the care of some of our most difficult children and adolescents. This column invites papers that describe the experiences of programs with this and other forms of community-based care. Also welcome are papers that present alternative concepts for the care of our more challenged young people. Diversity of thinking and experience are strongly encouraged. ♦

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Consumers will and should insist on robust participation in shaping their health care system. No system that makes choices and sets priorities will be accepted as legitimate without strong and effective consumer voice. The U.S. experiment with managed care has provided ample lessons on how health organizations can incorporate consumers into the management process. There is no excuse for not applying these lessons widely, whether in the present managed care system or the system or systems that will follow. ♦

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