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IMPROVING MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES FOR ADOLESCENTS

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ABSTRACT: This paper focuses on nine overlapping topics dealing with improving mental health and substance abuse services for adolescents and their families. Depending on the state of knowledge of each topic, the authors either highlight the importance of the area or offer a specific position statement. It is intended that these statements be reviewed for possible endorsement by the American College of Mental Health Administration (ACMHA) and for transmission to other professional organizations, federal and state governmental agencies and the field in general.

The intent of this paper is to build on four papers commissioned by the American College of Mental Health Administration (ACMHA) in 1990. These papers cover ethical issues (Dyer and MacIntyre), financing of services (McGuire), the service system (Friedman), and prevention (England and Cole). Each paper was reviewed by members of a specially appointed ACMHA Task Force, and the comments of Task Force members were utilized in preparing this white paper.[1] This article does not attempt to exhaustively summarize the content of the four papers. Rather, it selectively builds on these papers, and also draws heavily upon the experiences and perspectives of the co-authors of the White Paper.

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[1]It should be noted that the original intent of ACMHA was a formal task force meeting at which the four commissioned paper could be reviewed, and to have the White Paper prepared by Burns, the task force chairperson; unfortunately, funding to support this meeting was not available, and instead written comments of the task force members were solicited by the task force chair. Also, illness prevented Burns from assuming the lead responsibility for preparation of the White Papers, as originally planned.

BACKGROUND

Before examining the specific issues, it is important to provide a context for the discussion. From an epidemiological perspective, in his paper, Friedman (1990) highlights an increased prevalence and severity of problems in adolescents, as well as an earlier age of onset of many problems. He particularly identifies a major change in "the familial, social, and cultural supports and context for adolescent behavior. Adolescents are more frequently becoming victims of violence and of the loss of significant individuals in their lives, and are growing up in a context of increasing instability within their families and weaker familial and cultural supports." Burns (1990) points out that our efforts to serve adolescents are beset with what initially appears to be contradictory problems of "access and excess." By excess, she indicates that "a small number of children use most of the available resources, mainly extensive inpatient and residential treatment center (RTC) care, which is costly. Seventy percent of the child mental health dollar goes toward these institutional services and the care is not necessarily effective."

Review of the research by Burns and Friedman (1990) indicates, "the least amount of mental health services research has been done on the most restrictive and most heavily reimbursed treatment settings, namely hospitals and residential treatment centers," and the growth in inpatient psychiatric hospitalization is taking place in the absence of research support for its effectiveness. Another review specifically of outcome studies of inpatient psychiatric treatment (Pfeiffer & Strzelecki, 1990) found 34 published studies. However, to find this many studies the authors had to combine studies dealing with inpatient hospitals, and residential treatment centers, different age groups, and varying lengths of follow-ups, and to include studies lacking comparison groups. While 23 of the studies included post discharge data, only two reported such basic statistics as means and standard deviations.

While there is extensive use of inpatient and residential treatment settings, there is a general problem of inadequate use of other services by adolescents. In a review of existing data bases for the U.S. Office of Technology Assessment, Burns, Taube, and Taube (1990) found that only 1.7% of adolescents receive any type of mental health care in the course of a year. These data are likely to be an underestimate of the actual percent because they do not include all mental health settings, such as private practice settings. However, they still suggest a considerable problem in linking individuals with needed services, particularly in light of recent epidemiological estimates that the point prevalence of emotional disorders in children and adolescents is at least 14% and may be as high as 22% (Brandenburg, Friedman, & Silver, 1990; Costello, 1989).

The overall status of services for youngsters is perhaps best summarized by Congressman George Miller of California, Chair of the Select Committee on Children, Youth, and Families (1989). He indicates that

> "As many as 9.5 million children suffer from serious mental health problems, ranging from conduct and eating disorders to attention problems and depression. By every report to our committee, these children are increasingly younger, more violent, and more disturbed. Yet appropriate treatment, especially family-focused, community based care is scarce. As a result, the majority of troubled children receive either inappropriate care, or none at all."

It is against this background of increasing prevalence and severity of problems, a reduction in the availability of familial and community supports for youngsters, an extensive use of expensive and restrictive services and an under-utilization and lack of availability of mental health services overall, that the specific issues are identified and examined in this white paper.

MAJOR ISSUES

Organization of Service Delivery Systems

Organizing service delivery systems so that services are provided accessibly, comprehensively, effectively, timely, in an integrated cost-effective manner, and consistent with an agreed upon set of values and principles is complicated and difficult. It involves important issues between different levels of government, different public agencies, both the public and private sector, professionals, families, consumers, and funding sources and it must keep in mind the needs and diversity of the particular target population that it is addressing.

The development of a model of a community-based system of care for children and adolescents with serious emotional disorders has been a priority of the Child and Adolescent Service System Program (CASSP) of the National Institute of Mental Health (NIMH). This model (Stroul & Friedman, 1986) has been widely used, and served as a guideline for states in the development of the mental health plans they were required to develop for children and adolescents, as part of P.L. 99-660, the Mental Health Planning Act. Other models of community-based systems of care for those youngsters with the most serious problems have been developed, and to some extent are being tested (Behar, Holland, & MacBeth, 1987; Jordan & Hernandez, 1990; & VanDenBerg, 1990). The Robert Wood Johnson Foundation has mounted a major effort to "demonstrate that, through a collaborative effort between states and local communities, services for children and youth with serious mental illnesses can be organized, financed, and delivered far more effectively" (Beachler, 1990), the state of North Carolina, with funding from the Department of Defense, is embarked on a major demonstration and evaluation of a community-based system of care for military dependents in the Ft. Bragg, North Carolina area, and California is replicating the influential Ventura County Children's Demonstration Project in three sites.

The availability of system of care models is important and useful. Although there is always room for improvement the models of care for youngsters with

serious emotional disorders appear to be further along at this point than those for other populations. The major need of models for youngsters is further empirical testing, and for modification based on the research results. But the situation is different for other problem areas. For example, as Behar (1990) has pointed out, there has been less work on developing models of systems of care for adolescents with substance abuse problems than for youngsters with emotional disorders. Further, in the prevention/early intervention area, the focus has been more on the identification of risk factors and the development of specific intervention models than it has been on the establishment of overall models of systems of care.

The task of building models of community-based, multi-agency systems of care for prevention/early intervention and substance abuse is largely a conceptual and integrative one. There is a need to pull together the best available findings from the research literature, and from the field experience of providers, administrators, family members, and consumers to develop models that can be applied and tested. ACMHA can play a leadership role in response to this need either by organizing task forces to undertake these tasks, or recommending to appropriate federal agencies and funding sources that such efforts be undertaken.

Prevention

In their commissioned paper on prevention, England and Cole maintain that prevention needs to be elevated in importance on the mental health agenda, based largely on the "increasing prevalence of mental disability precipitated by trauma to vulnerable children and families." This recommendation to increase preventive efforts is certainly deserving of strong support.

England and Cole argue convincingly that a new language and approach to prevention is needed, and that such a new approach should be targeted at specific achievable goals rather than addressing "such global social welfare agenda as the elimination of poverty, social injustice, and general social entropy." This proposal that prevention in mental health be re-conceptualized as "targeted early intervention" is also deserving of strong support.

It is important that this more focused approach to prevention be based on a sound conceptual, systems, and programmatic base. England and Cole talk about the avoidance of "rotten outcomes" for youngsters. The concept of "rotten adolescent outcomes" is borrowed from Schorr (1989) who emphasizes the inter-relatedness of many of these outcomes, including emotional disorders, delinquency, dropping out of school, teen pregnancy, and substance abuse. Schorr maintains that, to a large extent, these outcomes can be traced back to an overlapping if not common set of risk and protective factors.

What are the implications of Schorr's position for us as mental health professionals interested in targeted early intervention? Does it not suggest the need to determine, first of all, if there are specific risk and protective factors

that have an effect on emotional disorders that differ from their effect on the other problems that Schorr discusses? If there are such risk and protective factors that are specific in their effect, then the appropriate focus of early intervention efforts may be to strengthen these protective factors and reduce the impact of the risk factors. This might best be done then through new services funded through categorical appropriations to mental health providers.

A new language and approach to prevention is needed.

If, however, for the most part there are a common set of risk and protective factors that are related to a range of disturbing adolescent outcomes, then there may be a special need to take a multi-agency, holistic, family-focused, and non-categorical approach to service. The critical issue then may be that there be some lead agency that is clearly responsible for serving high-risk children and their families, and that the approach of this agency is family-focused and holistic rather than more narrow and categorical.

In this regard, the major problem that the field has in shifting to a more preventive focus may in fact not be one of treatment technology but rather of systems organization. Who should be responsible for serving high-risk children and families when the problems may involve child welfare, education, mental health, developmental disabilities, physical health, substance abuse, and juvenile justice? And how can accountability mechanisms and fiscal incentives be established to support early intervention services? The development of effective accountability mechanisms requires identifying measurable benchmarks that are empirically related to subsequent performance. The establishment of fiscal incentives requires modifying highly categorical approaches to funding which create incentives for providers to figure out creative mechanisms of cost shifting rather than creative procedures for support and serving families.

Perhaps the most dramatic effort to address these system issues is taking place in two jurisdictions in Iowa where both de-centralization and de-categorization have taken place to establish one local entity not only as the accountable entity for serving children and families, but as an entity with a clear fiscal incentive to do so cost-effectively. To make it possible and financially desirable to provide effective early intervention services, 28 different funding streams have been collapsed into a general pool of more flexible funds under the control of this one local governmental entity. The absence of effective early intervention means that this one agency will bear the cost of its failure rather than being able to shift the cost either to another agency or a state-level arm of the same agency.

One of the challenges in the field, without question, is to shift to more of an early intervention focus. However, unless there are data to indicate that there are particular risk and protective facts that are specifically related to the subsequent development of emotional disorders and are not also related to

other undesirable adolescent outcomes, the task facing mental health professionals and agencies is one of working in partnership with other professionals and agencies rather than alone. It is possible and necessary for the mental health field to be targeted and focused in its efforts, without, on the one hand, addressing issues that are too global and broad, and on the other hand, restricting itself to an excessively narrow focus.

Further, the task is one of the modifying systems particularly to enhance accountability and modify fiscal incentives. Unless this is done, there will continue to be a system that is focused on crisis, in which high percentages of increasingly scarce resources are used for expensive and restrictive services, and in which effective early intervention models remain as isolated examples of what could be rather than parts of integrated systems of early intervention.

Professional Training and Overall Human Resource Development

In his paper, Friedman has argued for a major re-examination of the entire professional training and human resource development area. Is there a need for a major change in this area, or is it simply an issue of fine tuning? Existing mental health disciplines are largely adult-oriented. If the field continues on the present track, is it likely to be able to produce enough professionals who are interested in serving children, adolescents, and their families, and are these professionals likely to be adequately trained?

Given the changes in the nature of the population of youngsters to be served, there is a pressing need to assure that professionals are well-trained to deal with issues such as physical and sexual abuse, separation and loss within the family, adoption, depression, aggression, substance abuse, and biological bases of behavior. There is also a need to insure that they have skill in working in many different ways with families, in providing services outside of traditional mental health settings, and in working with culturally diverse populations.

Other changes have taken place with regard to issues such as individualized treatment, the role of the family, intensive community-based alternatives, family preservation services, cultural competence, approaches to prevention and early intervention, and multi-agency systems of care. There have also been significant practical changes in the approaches to assessment and treatment planning, and the array of treatment alternatives now available. These are changes that affect practitioners both in the public and private sector.

As all of these changes take place, it is recommended that the whole area of professional training and human resource development be re-examined. The question of the appropriateness of existing curricula and training models is but one question to be addressed. As already indicated, another question is whether the continued reliance on professionals from traditional mental health disciplines will produce the needed number of well-trained individuals.

Is there a need for new training approaches that focus specifically on children and families, rather than incorporating them as part of a program that is predominantly adult-oriented? At a time when the needs of adolescents and

families are serious and diverse, and require involvement of many different agencies and professionals, how can we best prepare students to understand both the clinical issues and the system issues? At a time when supports for children and families are growing weaker, is there a role for existing professionals or a new group of professionals to provide more ongoing support and service? If this type of more extended service is to be provided, are there health and strength-oriented models rather than pathology or defect-oriented models that can and should be used? If a case management function is of growing importance to the field, how can the mental health disciplines and the field in general best address this need? What should the role of family and consumer input be in the development of professional training programs, and how can change be made in these programs, given their often strong resistance to change?

ACMHA can provide a major service to the field by conducting itself, or promoting the need for others to conduct, a comprehensive examination of professional training and human resource development issues. Such an examination obviously must have strong input from professional organizations, but must also include a strong and active role of families and consumers, and public administrators and policy makers.

Role of Consumers and Families

There is an increasing recognition in the adult mental health field and a beginning recognition in the children's field that consumers and family members are entitled to and should be involved to a greater extent in planning, monitoring, and perhaps even providing mental health services. The Mental Health Planning Act requires that states actively involve consumers and family members in planning, and NIMH review procedures for state plans involve significant representation of consumers and family members. In the adult system, there is talk of "consumer-driven" systems of care.

In the child and adolescent mental health field, the recognition of the value of family involvement has also grown during the 1980s. The CASSP effort of NIMH has placed a major focus on this, largely through the efforts of the Research and Training Center at Portland State University, a new national advocacy group of families has been organized (the Federation of Families for Children's Mental Health), and other family advocacy groups, such as the National Alliance for the Mentally Ill, have increased their focus on children and adolescents.

These developments are very positive and encouraging. Yet, from an ethical standpoint as well as from the standpoint of developing a system of services that is responsive to the needs and desire of consumers and family members, there is much more to be done.

In their paper, Dyer and MacIntyre refer to "retaining professional stewardship." What does this mean and is it desirable? Should there not be increased involvement of families in such areas as service system planning, implementa-

tion of accountability mechanisms for programs and systems, identification of research priorities, review and modification of training curriculum, and development of quality assurance procedures? Should not consumers and family members plan an increased role in the provision of services for themselves or their family members?

A culturally competent system of care should include participants from varying backgrounds

ACMHA should take a strong position endorsing enhanced roles for consumers and family members in relation to various treatment, policy, systems, research, and training issues. Such a move towards more parity of family input with professional input is clearly desirable from an ethical standpoint. It will also help strengthen the system by providing much needed information on how to make services user-friendly and more effective, and by increasing the number of committed and articulate advocates for improved services.

Beyond the question of endorsing a stronger role for consumers and family members, there are several important specific questions that need to be addressed by professionals, family members, and consumers together. One of these is the role of family members and consumers with regard to particular activities. Should it be the same, for example, in reviewing plans for improved service systems as it is in reviewing research proposals or quality assurance plans?

It must also be recognized that in services for adolescents compared to adults, the question of who is the consumer and what the rights and roles of the adolescent and family should be are less clear. As Dyer and MacIntyre point out, "the whole area of competence, rights and confidentiality with respect to minors is a legal 'grey area' or quagmire," with great variability from state to state. It is important that this entire issue be further studied both to clarify rights from a treatment perspective, and to insure that input from the actual direct recipients of service be considered, along with input from their family members, in efforts to strengthen systems.

Finally, it is imperative that input by family members and consumers include adequate representation from all socio-economic levels, a wide range of racial and ethnic backgrounds, and a broad set of clinical issues. Clearly there is no one single parental or consumer perspective, and the goal should be to be inclusive of participants from varying backgrounds to increase the likelihood of well-rounded representations. This is one important step in developing a culturally competent system of care.

Accountability

The lack of adequate accountability in the mental health field hinders our ability to learn from our experience, to allocate resources effectively, to identify unmet needs, to communicate these needs effectively to others, and to generate

confidence in funding sources about the importance and value of our services. This lack of adequate accountability and failure to focus on outcomes of services occurs at the level of the individual practitioner, the program level, and certainly at the system level. For example, as reported earlier, according to Burns (1990) about 70% of expenditures for mental health services are for services in restrictive and expensive inpatient hospital and RTC settings. Yet there is little overall accountability or evaluation to determine the outcome of the enormous expenditure for these services.

The need for accountability exists for older and more traditional services much as it does for newer and less traditional services. It exists for services in the public sector and services in the private sector. It includes measures of process and equality, but must go beyond that to include measures of outcome. For example, there is much concern about the appropriateness and effectiveness of services provided by private for-profit hospital chains in inpatient psychiatric settings, despite the fact that the member hospitals of these chains follow quality assurance practices that earn them accreditation from the Joint Commission on the Accreditation of Health Organizations. While there are many reasons for this, one of them is clearly a need for accountability procedures that go beyond quality assurance methods and look at overall effectiveness in serving clients in a socially responsible manner.

The accountability procedures that do exist rarely take a consumer or family perspective. An exception to this is the bi-annual rating of state mental health systems, fondly (or not so fondly) known as the Torrey Report, and conducted by the Public Citizen Health Research Group and the National Alliance for the Mentally Ill (Torrey, Erdman, Wolfe, & Flynn, 1990). While there are many concerns that have been and can be raised about the methods of this group, the validity of their findings, it has proven to be an important mechanism for families and consumers to hold systems accountable.

Is this a model that can be expanded? Perhaps a "Consumer's Report," or "Torrey Report" on hospital chains would be helpful, given the concern about potentially exploitive, misleading and harmful practices.

Within the overall human services arena, the problem of lack of adequate accountability is certainly not unique to the mental health field. Nonetheless, both as users of public resources and as professionals offering services to the general public, the mental health field has not only a practical need in learning how to improve its services but an ethical and social responsibility in directly addressing its shortcomings in this area.

Ethics

In their 1990 white paper for ACMHA, Elpers and Abbot (1990) indicate that, "As professional roles change, ethical codes must be reevaluated and frequently revised. If its ethics are incompatible with its role, a profession is at risk of deteriorating to a trade group or less."

Dyer and MacIntyre, in their commissioned paper on ethics, highlight the

fact that there has been a dramatic change in professional roles with the increased emphasis on provision of mental health and substance abuse services by for-profit providers. Dyer and MacIntyre (1990) report that,

> "It must be acknowledged that professional groups have always straddled the fence of self-interest and public interest. The uncoupling of ethics and economics that has occurred as a result of the pro-competitive strategies of the last two decades have resulted in striking changes in the way health care is delivered. The market has provided opportunities, which have been met by a trend of privatization, for-profit care, and nowhere is this more notable than in adolescent mental health and substance abuse services. With these changes have come a host of new issues and the need to reconsider some of the ethical principles which might govern the behavior of providers in the marketplace."

This issue of the uncoupling of professional and business ethics as the profitability of inpatient psychiatric care has grown is perhaps the most important ethical issue currently facing the field given the controversy and abuses reported to take place, and given the impact of those abuses on the credibility of the entire mental health field. Dyer and MacIntyre cite Friedson as defining "a profession as an occupational group which society trusts enough to allow it to be self-regulating." Given the potential and real misuse of mental health services, particularly for profit and social control, the manner in which mental health professionals respond to the ethical challenges raised by the increasing profitability of inpatient care will have great impact not only on the credibility of the field, but also on the degree to which it is allowed to be self-regulating.

Elpers, in reviewing the paper by Dyer and MacIntyre as part of the ACMHA Task Force, offers the following recommendations:

1. No mental health professional admitting and treating a patient in any setting/ organization should have his or her income or capitol appreciation determined by the financial success of the organization. The only exception is the salaried professional who would lose a job if an organization went bankrupt. Salaried individuals should be local to and work for their organizations. Their loyalties are clearly evident.
2. Ethical administrators should not attempt to compromise clinicians as in #1 above.
3. Clinicians with financial conflicts of interest should have warning labels tattooed on their foreheads.

These recommendations, which presumably might use a dollar sign as the tattoo, are directed towards clinicians and administrators and represent a strong stand to at best avoid conflict of interest, and at a minimum to be open and up front about any potential conflict. It is recommended that ACMHA endorse these positions.

It is recognized, too, that professional organizations, such as the American Academy of Child and Adolescent Psychiatry, have promulgated criteria for admission to inpatient psychiatric settings as a means to reduce inappropriate admissions. Further, insurance companies have instituted more rigorous utilization review procedures, including in many cases pre-admission certification requirements, as an additional control on this problem.

However, criteria for admission, continuation, and discharge from hospitalization are inevitably subject to broad interpretation, whether by admitting professionals, insurance companies, or utilization review organizations. Each of these groups has a vested interest in the outcome of this decision-making process as well.

Weithorn (1988) has recommended the establishment of an independent review process for youngsters being admitted to inpatient psychiatric settings. This process would be used for voluntary admissions, since what is stated to be genuinely informed voluntary consent for admission often has strong elements of coercion, an inappropriate admission to an inpatient setting carries significant risk to the adolescent and family (Friedman, 1990b; Weithorn, 1988). This review process would be carried out independently under guidelines prepared by the responsible public mental health agency by individuals with absolutely no financial interest in the outcome within the first few days after admission. Such a procedures should not decrease accessibility of service to those genuinely in need and desirous of the service, but should provide an important protection against inappropriate sue of the service. As a further statement of its strong concern about potential misuse of psychiatric hospitalization, ACMHA should call for such an independent review process.

It should be noted that prior sections of this white paper have addressed other important ethical issues concerning adolescent mental health and substance abuse services. These have included the need to clearly establish the rights of adolescents to consent to their own treatment, the right of family members and consumers to be involved not only with treatment of themselves or a family member but in addressing broad system issues, and the need for increased clinical, program, and systems accountability.

Financing

There are at least five different broad categories of financing issues that are critical to providing effective mental health services. These are: Relationships between different levels of government and organizations within a particular level; the use of fiscal incentives to attain system objectives; third party payments and payment system design both in the public and private sector; the flexibility of funding both between funding categories and within individual categories; and the different methods of paying for services.

It is possible to address only a few of these issues here. In his commissioned paper, McGuire has focused on payment system design, particularly through the private sector. He indicates that the payment system should provide protection against the financial risk of serious illness. While these guidelines are certainly reasonable, it is essential as well as to ensure that the benefit package provides adequate flexibility with regard to the types of services that will be covered, particularly so that family and community-based services can

be eligible, diminish any fiscal incentive for hospital use, and provide adequate amounts of coverage for outpatient services.

It is encouraging that recent changes in Medicaid legislation may now make it possible for coverage of family and community-based services to be expanded. These changes also facilitate using the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program more effectively to identify emotional problems and provide effective intervention. It is essential that states receive adequate technical assistance so that they can unravel the complexities of Medicaid policy to determine not only how to best use their state resources to leverage federal funds, but most importantly, how to do it in a manner that promotes the achievement of community based systems of care.

A significant portion of youngsters do not have insurance.

As another critical part of the development of such systems of care, it is important that there be adequate decentralization of funding from state to county levels. As Dickey and Goldman (1986) have pointed out, "It is evident that if local units of government want to improve the current delivery system of care to the chronically mentally ill, localities must have greater financial control of the resources available to them for that purpose." The same clearly applies for systems of care for children and adolescents. Such decentralization must be accompanied by adequate state-level monitoring and accountability procedures. While the state uses funding procedures that create incentives for communities to provide home and community-based services, it must also adopt funding formulas that take into account the differential ability of counties to generate revenue.

As Friedman points out in his paper, the expansion of individualized care is one of the more encouraging developments in recent years. This approach, to be properly utilized, requires increased flexibility within individual funding streams. At the same time it is important to explore through carefully developed innovative projects the benefits of more de-categorized approaches to funding, such as the project already under way in Iowa.

Strategies of "empowering" families through providing them with direct cash payments rather than actual services should also be tested. By providing family members with control over the dollars, it converts them into a consumer with power, and may result in a more responsive service system. Such models exist widely in the development disabilities fields, and are just beginning to be explored in the children's mental health field.

The new Ft. Bragg demonstration project in North Carolina represents one of the most exciting opportunities to test changes in financing strategies, and should be closely watched. Under this model, Department of Defense funds

can be used in a flexible manner consistent with values of family and community-based services. Other such tests are needed in both the public and private sector, and particularly linking the public and private sector. Different contracting models between public and private sector that insure accessibility of services, perhaps provide services to public sector clients at discounted rates, serve those most in need a top priority, and manage client care so as to control costs while providing effective care are needed.

It is important to recognize that a significant portion of youngsters do not have insurance coverage. This is particularly true for minority children, who are over-represented among children living in poverty. While it is beyond the scope of this paper to discuss this in detail, the significant number of individuals without any insurance coverage clearly indicates the need for universal health insurance. As Elpers comments, such universal health insurance should include "basic mental illness care for serious disorders as well as targeted early intervention."

Overall, it is encouraging that financing is beginning to receive the attention that it merits. There are many important issues that will require continual attention. It is essential that financing policy be viewed as one of the major ways in which funding agents, public and private, operationalize their values and create incentives to implement services according to their values and their objectives. In this regard, it is extremely important that efforts and payment system redesign emphasize both office-based and home-based outpatient services, and that public system financing policy contain adequate local control and budgetary flexibility to enhance the development of community-based systems of care. At the same time as these broad issues are addressed, it is also recommended that there be developed and tested new strategies for public-private partnerships, allocation of resources directly to families, and expanded de-categorization.

Services for Minority Adolescents and Their Families

For any mental health service delivery system to be effective, it must be capable of serving a culturally diverse set of individuals. This is particularly true for a system focused on youngsters and their families, since minority groups such as African-Americans, Hispanics, and Native-Americans are over-represented in percentage of children living in poverty, and typically over-presented as well in systems such as child welfare, juvenile justice, and special education. In addition, the population in the United States is becoming increasingly more diverse, including increasing numbers of Asian-Americans, for example.

The challenge to the mental health field is a broad and difficult one. It includes examining the basic etiological and taxonomic models for health and illness in the mental health field to distinguish between those relationships and

conditions that withstand cross-cultural tests, and those that are unique to particular cultures. It includes studying intervention models to determine their appropriateness for culturally diverse groups, and establishing more flexible models that conceptually build upon knowledge of the effects of cultural variables, and practically incorporate approaches that are relevant to and build on the strengths of different racial and ethnic groups. It certainly includes examining curricula for professional training, particularly since within "bio-psychosocial" models it is most typically the sociocultural part that is neglected, or added as an afterthought.

The Minority Initiative Resource Committee of CASSP, under the leadership of Cross and his colleagues, developed a model of a "culturally competent system of care" (Cross, Bazron, Dennis, & Isaacs, 1989). The publication of a monograph describing this model was followed up by a national conference in Boulder, Colorado, in July 1990.

What are the precise implications of this model in areas such as models of health and illness, diagnostic systems, professional training, development of service delivery systems, clinical practice, agency policies, and research efforts? The challenge is to explore each of these issues in an effort both to enhance the ability of the mental health system to serve a culturally diverse population, and to determine the extent to which the basic theoretical and clinical models in the field are consistent with the best cross-cultural research.

An important step for ACMHA, as well as for other professional organizations, is to examine its own policies, practices, and premises to see if they incorporate an adequate awareness and responsiveness to the importance of cultural differences. ACMHA can then assume an important role in working in partnership with other groups to examine the steps that mental health professionals need to take to improve their level of cultural competence.

Research

As complicated as many of the issues are, there is a need for more research, particularly on service delivery and systems of care. The recent "National Plan for Research on Child and Adolescent Mental Disorders," submitted to the U.S. Congress by the National Advisory Mental Health Council, recognizes that need. It indicates that, "By examining and evaluating the structure and process of existing service delivery systems, by testing innovative changes in these systems, and by developing and testing new service models such research can provide a basis for developing much more effective and appropriate forms of service delivery to children and adolescents with mental disorders" (National Advisory Mental Health Council, 1990).

The need for expanded research, particularly from a systems perspective, should be supported by ACMHA and presented to such funding sources as NIMH, National Institute on Drug Abuse, National Institute of Alcoholism and Alcohol Abuse, and the Department of Education.

CONCLUSION

ACMHA is commended for initiating this examination of issues related to adolescent mental health and substance abuse services. This white paper has discussed nine important issues based upon four papers commissioned by ACMHA, and based upon general developments in the field. The nine issues are the organization of service delivery systems, prevention, professional training and human resource development, role of consumers and families, accountability, ethics, financing, services for minority adolescents and their families, and research.

In each of these areas, the authors have stated their positions and offered recommendations. In each of the areas, ACMHA has the expertise to follow-up on the recommendations either in their present or modified form to make a significant contribution to improving services. It is certainly the hope of the authors that this white paper will prove useful to ACMHA and the field in leading to important steps to improve services.

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