Helping Troubled Children: Divergent Discourses

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The history of child mental health services in the United States in the past 100 years is notable for the development of 2 different traditions, one arising from professionals, the other from advocates. We review these 2 traditions, often divergent, and argue that closer collaboration would benefit the children and families served by these traditions.

As troubled children were increasingly seen during the 20th century to have treatable conditions, services arose in mental health settings, juvenile justice, child welfare, and special education. This tradition was led by those with expert knowledge, often linked to academic centers. Nonetheless, most troubled children received no help at all.

Controversies arose because these expert-driven services were
- often fragmented and discontinuous or provided only in residential centers far from home;
- based on diagnoses, often missing children’s strengths;
- often blaming or excluding of parents; and
- often lacking in cultural understanding.

In Unclaimed Children,1 Knitzer showed that most troubled children were not getting help, and some of the most experienced clinicians treated the small number deemed “treatable.” Schools and social agencies often worked in isolation from each other. The perspectives and experiences of parents were not routinely incorporated.

Knitzer’s work inspired a second tradition, that of “systems of care” (SoC). This tradition emphasized the coordination of services from agencies, schools, and clinicians.2 Individual “wraparound” services aimed to enhance expert-driven care with planning that centered on the family and was based on strength. Supported by the federal government through the Substance Abuse and Mental Health Services Administration, these programs grew, produced literature, and held annual conferences. Wraparound programs in many states currently include a range of staff, professional and nonprofessional (including “parent partners,” i.e., parents with lived experience as parents of troubled youth), and use an approach that is meant to be centered on the family, guided by youth, and culturally competent. By 2006, 98,000 children were served in such programs.3

Table 1 presents a summary of the key differences between the 2 traditions.

DIVERGENCE

Although some centers and programs work in collaboration, in many ways the 2 traditions diverge.

- At the annual meeting of the SoC movement at Tampa, there is no discussion of clinical services.
- Reviews of the SoC movement, although reporting a quarter century of progress in implementing wraparound services for children at risk, do not discuss the concurrent changes in expert-driven child mental health, especially the extension of psychiatric diagnoses to young children and the increased use of psychoactive medications in the young.
- Although families’ current attitudes to the use of psychoactive medication for children range from seeking to shunning medication, the SoC literature has little discussion of such variation, missing an opportunity to describe how planning care varies depending on the family’s attitude.
- Although controlled clinical trials of SoC interventions have shown limited effect of wraparound by itself in improving child functioning and highlighted the need for better definition of clinical interventions, subsequent reviews of the effectiveness of wraparound say little about the content of clinical interventions.
or the knowledge, skills, and attitudes care managers need to help parents access, assess, choose, and use clinical services. Even recent reviews have offered more robust data on cost savings than on clinical outcomes.4

One response to this divergence has been to argue that divergence is appropriate, because expert-driven clinical services and wraparound are fundamentally different. In this view, wraparound is not a clinical service, but a process of coordinating care that may or may not include expert-directed diagnosis and treatment. This seems an inadequate response for several reasons.

First is the role of expertise in planning care. The translation of “strengths and needs” into a plan of service is not simple. As a process of negotiation among family, professionals, and others, it deserves respect, study, and facilitation. To label it “nonclinical,” i.e., simply an administrative function, minimizes this process. A rich literature exists on collaboration and team performance; how can child mental health contribute to, and draw from, that “expertise”?

Second, which culture? What kinds of competence? All agree on the need for “cultural competence,” but culture is often taken to refer only to attitudes and behaviors common in ethnic and linguistic communities. In fact, the culture in which parents raise children is more than that. Parents vary greatly in their readiness to define their children as having a “mental disorder,” vary in their feelings about whether professional services have anything to offer, and vary in their attitudes toward medication. These opinions range from unwarranted pessimism to magical optimism.

Third is the need for an integrated knowledge base. The divergence described here has discouraged empirical research in each tradition. On the one hand, we know too little about the ways that “experts” and those with lived experience interact in SoC. We need to examine whether it actually makes a difference for children (in whom the “functional outcomes” occur) whether services are organized in one way or another. On the other hand, we need to know more about how interventions developed “blinded” to context can be applied in practical settings. What have the teams learned? How can systematic learning from that experience be made a regular part of each tradition?

### BRIDGING THE GAP

How to bridge this “divergence” and offer children and families the best that the 2 traditions can offer? Weisz et al.5 argued, in response to polarizing statements, that there was more to be gained by joining than by splitting. The ways that SoC and expert-driven care are set up must be restructured to include the lessons from the other. SoC need to track not only programs’

#### TABLE 1  Key Differences Between Two Traditions of Child Mental Health Services

<table>
<thead>
<tr>
<th>Systems of Care</th>
<th>Expert-Driven Care</th>
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<tbody>
<tr>
<td>Problem addressed</td>
<td>fragmented, inaccessible, or uncoordinated care</td>
</tr>
<tr>
<td>Relevant population</td>
<td>populations at risk and individual children and families</td>
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<tr>
<td>Interventions offered</td>
<td>team formation, development of shared vision; advocacy; ways to meet identified needs</td>
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<tr>
<td>Physician role</td>
<td>variable; if the child is on psychotropics, a physician is a part of the team; if not, consult as needed</td>
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<tr>
<td>Driven by strengths and needs identified by parents and team</td>
<td>services requested by parent, chosen in alliance</td>
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<tr>
<td>Reflects on, promotes process, fidelity</td>
<td>diagnoses, treatments</td>
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<tr>
<td>Which evidence supports? parent engagement, satisfaction</td>
<td>professional experience; positive treatment effects in research on selected populations</td>
</tr>
<tr>
<td>Blind spot “Clinical services? Yes, if a tool tied to an identified need”</td>
<td>“We already know how to listen to parents”</td>
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<tr>
<td>Attitudes reinforcing “If we’re parent-centered, we can identify whatever’s painful”</td>
<td>“We’re the ones with the expert knowledge; that’s what counts”</td>
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fidelity to endorsed principles but also actual outcomes achieved, such as improved mood, impulse control, school attendance, and family atmosphere. Expert-driven care must measure the context of care and its effects. For example, which families engage (or not) and what difference does such engagement make for outcome? Alternatively, which children respond (or not) to individual services? Moreover, does coordination, as opposed to fragmentation, of services make a difference in outcomes? Individual child differences, family strengths and challenges, and community assets and problems need to be considered in a way that fosters engagement, mutual respect, and collaboration. Although such care does occur, sporadically, our children need us to provide such care as a rule, not an exception. A child with a learning disability, depression, and untrusting parents will need compassionate engagement of his family, and an accepting approach by the school, and warm and thoughtful mental health care, and “expert” evaluation, and individualized appropriate education. The children and families we treat need and deserve this comprehensive, compassionate, and collaborative care.

REFERENCES