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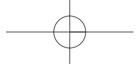
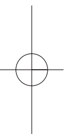
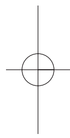
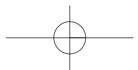


PART ONE

CONCEPTUAL FOUNDATIONS OF SYSTEMS OF CARE







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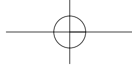
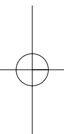
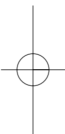
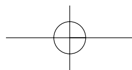

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CHAPTER ONE

A History of Community Child Mental Health

Ira S. Lourie

It is difficult to conceive of the history of community child mental health as separate from the history of child mental health itself. A large segment of the field of child mental health has always focused on the delivery of service in the community for the population of children in need regardless of their social status or standing. In fact, the earliest child mental health services were aimed at a population of homeless and wayward youth, following from an advocacy movement that grew out of the industrial revolution at the end of the nineteenth century and the spate of immigration at the beginning of the twentieth century in the United States. The child guidance movement grew out of these early beginnings and focused on serving the entire population. As a result, by the time the formal community mental health movement began in the United States in the early 1960s, the concepts of treating the mental health needs of children and adolescents in the context of their communities were already being practiced by child guidance centers and had become the accepted practice of the field.

Over the more recent history of the child mental health movement, several underserved populations have emerged around which the need for specialized community mental health services has been recognized: the alienated adolescents of 1960s and 1970s and children and adolescents with severe emotional disturbances as recognized in the 1980s. This chapter traces the four major community mental health movements for children that have occurred over the past hundred years: child guidance, the community mental health center program, the alternative youth

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services movement, and now the system of care concept for children and adolescents with serious emotional disturbances and their families.

CHILD GUIDANCE

The history of child mental health began as a progressive movement toward social welfare in the late nineteenth century described as the "child savers" (Jones, 1999). This group of advocates aimed at rescuing wayward children from the destructive forces of poverty. This movement then expanded to ameliorating the effects of those same forces, along with mental retardation, as the causes of juvenile delinquency. Beginning in the 1880s, problematic behavior in children, most often manifesting as delinquency, was seen as the product of moral and mental defects, compounded by the lack of appropriate resources. While one might find these concepts simplistic and antiquated by today's standards, we should be reminded that poverty and racism remain overwhelming social problems that leave their mark on the development and mental health of children growing up in their shadows.

Jones (1999) describes the forces that moved child mental health to a more professional child guidance during the first thirty years of the twentieth century. The first child mental health services began as child guidance clinics that functioned much like court clinics today. The first child mental health service agency, which was in Chicago, still bears its original name, the Institute for Juvenile Research, and another of the still existing early such programs, the Judge Baker Child Guidance Center, was named for the judge who was instrumental in its inception.

Child guidance was aimed at guiding youth in the right direction. Jones (1999) describes a Judge Baker Foundation document from 1915, *Strengthening the Twig,* which presents the concept of taking a young organism and helping it grow in the proper straight direction. A general professional acceptance of this premise is reflected in the fact that the primary professional organization for child mental health professionals from 1930 through the 1970s was the American Orthopsychiatric Association, in which the term *orthopsychiatric* is derived from the Greek root of the word *ortho,* meaning to straighten.

The first major advancement in our understanding and treatment of children and adolescents with problematic behavior that grew from child guidance was the shift from punishment to correction: we should fix troubled children, not further harm them. This community-focused concept was built on the premise that if children and adolescents misbehaved, it was not necessarily their own fault. Rather, society was to blame because it deprived youth of the resources necessary to meeting their needs. The accepted position that most delinquents came from the lower economic sectors of society was used as support for this

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supposition. At the same time, early thoughts on individual and family development were emerging, building on the earlier understanding that development was affected by economics and organicity (primarily retardation).

In the 1920s and 1930s, child guidance expanded from a primarily delinquency-based movement to one aimed more at the middle and upper classes. Jones (1999) calls this the "popularization of child guidance," which was driven by both the desire for mental health professionals to have their gospel more generally accepted and a youth movement of the 1920s unlike any before it. A broad audience for child guidance followed from a growing understanding that problematic youth behavior was found in all classes. Jones's theory is that the public became fascinated by the Leopold and Loeb trial of two upper-class youth convicted of a senseless murder, which led not only to a focus on upper-class problems but also served as a lesson in the relationship between developmental issues and youth behavior. What followed was a conceptualization of delinquency prevention, which led to a better understanding of how the deviations from the normal developmental course could lead to poor behavior. A movement followed from this to teach parents how to avoid these problems by using better methods in rearing their children.

Most of the early growth in the field of child mental health that Jones described consisted of a new understanding of children and their development and was exemplified by the focus on individual development, the role of the family in that development, and the effects of societal forces that children and families had to deal with. Unfortunately, it was during this era late in the first half of the twentieth century that child guidance accepted an increasing role as a private practice–like setting for middle- and upper-class populations. Although most child guidance clinics continued to provide publicly supported and charitable services to those who could not afford them, the field of child mental health as a whole slipped from being a primarily community mental health service to a private practice model.

COMMUNITY MENTAL HEALTH CENTER PROGRAM

A major shift in mental health policy in the United States occurred in the early 1960s with the advent of the Federal Community Mental Health Center program. In adult psychiatry, the public system had no community mental health alternative equal to the child guidance centers, and most communities did not have access to those centers. Public psychiatry consisted for the most part as state hospitals serving mainly a population with chronic psychotic disorders. For children, there were child guidance centers and some residential treatment, funded primarily as child welfare and juvenile justice institutions. The advent of phenothiazine treatment of

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psychotic symptoms in the 1950s had begun to create a population of adults with serious and persistent mental health problems who had been deinstituionalized and were living in communities.

Federal Community Mental Health Center Act

The U.S. Congress responded by the passage of the Mental Retardation Facilities and Community Mental Health Center Construction Act of 1963 (P.L. 88–164) to begin to meet the needs of this population. The purpose of the mental health portion of that legislation was to create a nationwide network of community-based mental health clinics that could serve this deinstitutionalized population, among others. The program was aimed at the development of community mental health centers (CMHCs) in every community in the country (the plan was to have one center for each catchment area of about 135,000 people). These centers were to provide five essential services: inpatient (short term), outpatient therapy, emergency services, crisis stabilization, and consultation and education.

Although children and adolescents were not excluded from the use of these services, their needs were not specifically addressed. Under the earliest iterations of the CMHC program, there was no requirement that services specifically aimed at children and adolescents be offered by the centers. As a result, the plight of children was left up to each center; unfortunately, only about half of the centers had any children's services at all (Ad Hoc Committee, 1971). Two major forces tended to inhibit the development of community mental health services for children and adolescents. The first of these was the predominance of adult focus within the field of mental health itself. This tendency, which still exists, causes the community mental health leadership not even to think about specialized services for children and adolescents. Some of this is related to their unfamiliarity with the differences in the needs of the populations. In addition, the needs of the adult population are so great that they alone could easily use up all the existing funds available and still require more.

The second factor is the high cost of children's services. CMHCs were most often created with money from the federal CMHC program, which offered start-up staffing grants and which decreased over the period of eight years (there were also some funds available specifically for the building of new centers). As the federal funds decreased, they were made up with state funds and other public and private reimbursement sources. For adults, this process worked fairly well. As the federal monies dried up, the state was able to replace them with state mental health funds (which had been primarily aimed at this population of serious and persistently mental ill adults in the first place) and with newly developed federal funding streams such as supplemental security income, Medicaid, and Medicare, all of which the adult mentally ill population had easy access to. Children and adolescents had less access to these sources of funding.

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Children's services require a greater degree of indirect services that are not reimbursable by most public or private insurance programs: informal case management tasks, consultation with schools and other programs for children and adolescents, and internal teaming time by the group of professionals at the mental health program who work with one family. During the time that a CMHC was receiving federal funding, many of these nonreimbursable child-oriented services were covered under the rubric of consultation and education services. But as soon as the federal monies were gone, state resources rarely were used to fill in, and the services dried up. When this happened, the cost of children's services became too high for the CMHCs to afford. Centers that had started children's services under the federal CMHC program dropped them when the federal monies went away, and other centers never even started them.

Compounding these problems was the fact that the state departments of mental health, which had the responsibility for continuing the CMHC program after the federal government's eight-year commitment was over, often did not have a child mental health capacity or expertise to support children's services. In 1982, Knitzer found that twenty-one states did not have a full-time person assigned to children's mental health services at the state level or a specific children's mental health allocation in their state mental health budgets. With such a lack of interest and support for children's services, it is no wonder that not many such services grew within the early days of the CMHC movement.

Part F of the Community Mental Health Center Act

The failure of adequate child and adolescent community mental health services to develop led child advocates to push for the development of a special child and adolescent program under the CMHC Act. In 1972, Congress passed an amendment to that act that provided for a special children's program, Part F. Part F was one of the most exciting advances in children's mental health services since the emergence of the child guidance centers some sixty years earlier. Under this program, around four hundred CMHCs developed and supported children's services, about a third of the total number of CMHCs (Lourie, 1992). Many of these children's programs were exciting and innovative and led the way to defining the delivery of mental health services to children, adolescents, and their families during that era. This program was deemed a success, and in 1974, the CMHC program was changed so as to require children's services in every federally funded CMHC. Unfortunately, the same CMHC act amendment of that year also added six other required services, raising the number from five to twelve but without increased funds to provide for these new services. As a result, each of the seven new services was insufficiently funded to be properly implemented, and status quo was the general rule. In addition, there were no longer special monies available to start new children's services as there had

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been under Part F. However, CMHCs that had received Part F grants did continue to receive these special children's funds for the full eight years of their original Part F grant.

Joint Commission on the Mental Health of Children

Around the same time that the Community Mental Health Center Program was started, there was another major step in community child mental health: the Joint Commission on the Mental Health of Children. Congress established this national study of the needs of children and adolescents with emotional problems in 1965. In *Crisis in Child Mental Health* (1970), the Joint Commission laid the framework for a child advocacy approach to children's services. This child advocacy reflected the full range of children's needs—welfare, corrections, education, health, and mental health—and was to be based on the principles of child guidance. This advocacy was felt to be needed at the national, state, local, and individual levels. Congress made two attempts to enact legislation implementing the recommendations of the Joint Commission, but both failed. This major setback for the field of child mental health reflected the waning of the federal government's commitment to child mental health from its earliest support of child guidance.

The 1970s saw few advances in community child mental health, and there was minimal impact from the Joint Commission in spite of the major advances in providing mental health services in general during that period through the national CMHC program, which was flourishing at its height nationwide, covering over half of the communities in the country with community mental health centers supported by federal monies. Unfortunately, this movement had little impact on child mental health because most of these community mental health centers offered few services for children and adolescents.

ALTERNATIVE YOUTH SERVICES MOVEMENT

One area in which there *was* a great deal of growth and change in the 1970s was the field of youth services. Like the founding child savers of the child guidance movement, a group of individuals became concerned about the spirit of alienation of the late 1960s and early 1970s between the youth culture and the adult culture (not unlike the forces of the 1920s that helped drive child guidance). Adolescents in the 1970s were less likely than prior generations to participate in the traditional child guidance approach. Not only were these youth rebelling against their parents as had generations before; they also rebelled against adult authority in general, including the professional authority embedded in child mental health. Child mental health as a field responded to these alienated youth with the popularization of family therapy, which sought to treat the problems of youth as the result of a family system gone wrong rather than focusing on the alien-

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ation itself. Family therapists viewed the problems of youth as being the result of dysfunctional dynamics that developed among various family members, including the youth.

Another response to this population was embodied by a totally new set of services that grew out of the youth work movement, which over the previous forty years had primarily focused on gangs and had little, if any, relationship to child mental health. From this service sector came what was to be called the alternative services: untraditional programs that viewed the alienation of youth from their families as a societal change rather than as a form of psychopathology. This new perspective dictated a different set of goals for mental health interventions. Mental health workers first needed to connect with the youth by helping them with the problems they perceived as important and only later, when the youth was ready to participate, offer counseling. Even later (and only if it made sense) did mental health workers try to reconnect these youth with their families. Drop-in centers, runaway houses, and multiservice walk-in services, as well as traditional street work, became the tools of the alternative service movement, while the formal principles of child guidance and community mental health were looked on as being irrelevant to the needs of youth. As we will see, these alternative services created the service milieu model in which many of the more innovative current child mental health services are provided.

THE SYSTEM OF CARE CONCEPT

Community child mental health is currently embodied by the system of care for children with severe emotional disturbances and their families. The conceptualization of the system of care derived originally from the underlying principles of child guidance and the findings of the Joint Commission on the Mental Health of Children. These principles were modified to fit the perceived service needs of the last two decades of the twentieth century and reflect the lessons of the alternative service movement of the 1970s.

The National Plan for Mental Health

The convening of the President's Commission on Mental Health in 1978 led to a major shift in mental health policy. The recommendations from this commission (President's Commission on Mental Health, 1978), which followed from first lady Rosalynn Carter's interest in mental health, were enacted through the development of a National Plan for the Chronically Mentally Ill, through which the National Institute of Mental Health set the course for the current era in spite of the fact that the children's chapter of the National Plan was relegated to the status of an appendix (Lourie et al., 1980). The President's Commission and the National Plan highlighted two underserved mental health populations: adults with

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chronic mental illness (today referred to as serious and persistent mental illness) and children and adolescents with serious emotional disturbances. The blame for this underservice was laid on the failure of community mental health centers to address these populations and meet these public needs adequately. The governmental response to the national plan was rapid for adults, and the Community Support Program, a very successful program to develop state and local social and rehabilitation resources for the population of those individuals with serious and persistent mental illness, which had been developed the year before, was expanded.

The Most-in-Need Program. The programmatic response for children was similar to that of the children's chapter of the National Plan: an appendix (Lourie et al., 1980). All that followed was a tiny program of services for those children who were most in need. This program, called the Most-in-Need Program, commonly known as MIN, had a strong community mental health focus and was conceptualized in a way to allow communities to apply the principles of the Joint Commission to those children in their locality with the most unique needs, no matter what those needs were and regardless of the degree of mental health focus reflected. Unfortunately, this program was never embraced by Congress or the National Institute of Mental Health in which it was developed. In fact, it was funded only by the Indian Health Service in the form of short-term grants in only twelve reservation and urban Native American communities.

The Mental Health System Act. The final result of the President's Commission on Mental Health was the 1980 passage of the Mental Health System Act (P.L. 96–398). Under this legislation, a federal grant program was to be developed that created community-based systems for approaching the needs of the underserved populations identified by the commission: chronically mentally ill adults (now recognized as adults with serious and persistent mental illness) and severely emotionally and mentally disturbed children and adolescents. Unlike the Community Mental Health Center Program, which created federal-local partnerships to develop these centers, the Mental Health System Act aimed at including state government as a more important and active partner in this local community mental health capacity start-up program. Including the state in the partnership process was aimed at encouraging the development of state mental health funding streams that would support those nonreimbursable services that the community mental health centers had tended to drop when the federal monies disappeared, under the Community Mental Health Center Program.

The Block Grant Program. The Mental Health System Act was never implemented. After a year of National Institute of Mental Health planning and developing both adult and child programs to create local mental health systems,

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the act, along with the entire Community Mental Health Center Program, was repealed and replaced by the Alcohol, Drug Abuse and Mental Health Block Grant Program (part of the Omnibus Budget Reconciliation Act of 1981, P.L. 97–35). The block grant concept was a governmental shift toward state control over the federal monies. The states were to receive all of the funds they had received previously under the Community Mental Health Center Program and prospectively under the Mental Health System Act to spend as they saw fit in their community mental health programs. There were some guidelines, but the result of the block grant legislation rapidly shifted the emphasis of using federal dollars from the development of new centers and systems to the ongoing support of existing centers; there were no provisions specifically allocating funds for children's services in the original act. So few new children's services or service systems were being developed under the block grant program that Congress instructed at various times that at least 10 to 25 percent of all monies to a state under the block grant be allocated to the development of new children's services (Lourie et al., 1996). This provision was never well monitored, and the block grant program has never proved effective in expanding children's community mental health services or creating service systems for the most severely affected children and adolescents.

Unclaimed Children

The full children's response to the President's Commission and the National Plan had to wait for six more years. In 1982, Jane Knitzer reported on her Children's Defense Fund–supported study of services for severely emotionally disturbed children and adolescents. The report, *Unclaimed Children,* documented the sorry state of services for children with the most severe mental health problems and the failure of federal, state, and local governments to respond to that crisis. This report has become a classic and served as the battle cry for a new wave of child advocacy based on the findings of the Joint Commission fifteen years earlier. Finally, in 1984, the federal government funded a program to meet the needs of this population better: the Child and Adolescent Service System Program, better known as CASSP.

The Child and Adolescent Service System Program

CASSP came on the scene at a time when the more serious the emotional problem or mental illness that a child or adolescent had, the more likely that that child would not be able to obtain the full range of appropriate and needed services. A comprehensive service system for children and adolescents had failed to be created. The roots that had grown into child guidance—child welfare, juvenile justice, special education, health, and mental health—had developed several major branches, each of which represented a branch of government that had taken some child mental health responsibility but which was no longer interconnected.

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Mental Health. Child guidance and community mental health centers were not playing a major role in providing child mental health services and had little public funding. These programs had come to act like private practices, primarily meeting the needs of middle-class children with mild to moderate problems. Ironically, youth with the most severe mental health problems were unable to find adequate services within mental health. They often found themselves in out-of-home services funded by welfare, justice, and education agencies. To obtain these services, a youth had to qualify for services from one of these agencies.

Education. The education system was a major route for a child to obtain mental health services. In 1974, the federal government passed special education legislation, known today as the Individuals with Disabilities Education Act. This law, originally known as the Education for All Handicapped Children Act (P.L. 94–142), was the result of a civil rights action brought on behalf of students who were being denied education on the basis of their disabilities. Its purpose was to entitle every child a free and appropriate education regardless of the restrictions created by a disability; this included emotional and behavioral problems. Children and adolescents whose education was being hampered by their emotional disabilities were required to receive those services, including, but not limited to, mental health and educational, that were necessary in order for them to learn. Regardless of the many exemplary education-based programs created across the country to serve the needs of children with emotional problems better, the system has never become complete or comprehensive in all jurisdictions, and many, if not most, school districts underidentify youth with emotional and behavioral disabilities or fail to develop the services many of them need (Knitzer, Steinberg, & Fleisch, 1990).

Juvenile Justice. The juvenile justice system was another avenue to obtaining mental health services that reflects its child guidance roots. But as Jones (1999) pointed out, the current movement in juvenile justice is away from guidance toward punishment; juvenile justice now has an increasingly adult penal orientation. As with education, many jurisdictions continue to provide excellent mental health services for their juvenile justice populations, and many court clinics still exist, but in general, appropriate services are hard to find nationally for the population of children and youth with serious emotional disturbances—ironically, just the population that the entire juvenile justice system was concerned with at the advent of child guidance.

Child Welfare. Child welfare agencies have become the most prominent among the child-serving agencies that support mental health services for the most seriously disturbed children and adolescents. Like juvenile justice, child welfare was closely connected to child guidance at its birth. This grew from the preponder-

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ance of troubled children coming from families struggling with poverty and other troubles and the propensity for these youth to be abandoned or become victims of domestic violence, and thus wards of the state. Many such children bounce from foster home to foster home, psychiatric hospitalization to psychiatric hospitalization, and finally to residential treatment, often out of state and far from their homes and families. Because child welfare may be the only agency with the resources for the purchase of high-intensity mental health services, many parents are obliged, sometimes forced, to give up custody of their child with emotional disturbance to the welfare agency. To do this, the parents must either declare themselves inadequate to the task of rearing their child or, more destructively, as being abusive.

An Interagency Approach. CASSP was developed as a federal program aimed at ensuring that children and adolescents with the most serious emotional problems would get their needs met without having to qualify for child welfare, juvenile justice, or special education services. A further goal was for mental health to work with these other systems in helping families obtain the full range of services that their children might need. CASSP was based on the original principles of child guidance and the understanding that children and adolescents with emotional problems and their families have multiple needs that must be met before the problems can be alleviated. Similarly, it was based on the principles of the Joint Commission and the concepts of child advocacy at the federal, state, local, and individual family levels. The embodiment of advocacy within CASSP is the concept of the system of care, which is a multiagency approach to the delivery of services that need to be community based, child centered, and family focused, as described by Stroul and Friedman (1986) in their classic monograph, *A System of Care for Children and Youth with Severe Emotional Disturbances.*

The first goal of CASSP was to encourage states and communities to create interagency systems of care for the purpose of ensuring that the multiagency needs of this population of children, adolescents, and their families would be met (Lourie, Katz-Leavy, DeCarolis, & Quinlan, 1996). Initially, individual states responded to this federal initiative by developing an interagency process at the state level that brought the mental health, child welfare, juvenile justice, and special education agencies together for joint planning of how they could work better among themselves. Ultimately, these state-level interagency processes were applied at the community level to create systems of care, the mission of which was to provide individual children, adolescents, and their families in those communities the most appropriate and better coordinated services.

CASSP's second major goal was to develop a better response for child mental health agencies within systems of care and to enhance their role within them. Many states and communities have a paucity of mental health resources available to participate in such systems of care. Knitzer had pointed out that fewer

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than half of the states had an individual at the state level who was responsible for child mental health services. And fewer than half of the states had a specific budget for child mental health services. These facts, along with the failure of community mental health to address the mental health needs of children adequately, left the population in need with few mental health resources and no governmental agency with responsibility for ensuring their availability. CASSP acted to create a specific child mental health presence in the governments of all states, increase state child mental budgets, and develop mechanisms for passing this increased state-level focus on child mental services down to the community level.

Enhancing the role of the family was another major goal of CASSP (Friesen & Huff, 1996). Early in its development, CASSP recognized the destructive nature of parent blaming that had first emerged in the early days of child guidance and was reified through the dysfunctional family concepts of family systems theory, and moved toward its abolition. The family was seen as the child's most important resource, even when the situation was such that the family was not able to care for that child directly for a period of time. If the system of care was to function properly, family members must help define it and run it, as well as benefit from its services. The parent movement that grew out of CASSP, embodied in the Federation of Families for Child Mental Health and the National Alliance for the Mentally Ill—Child and Adolescent Network and the numerous local chapters of these organizations, has had a major impact on improving the systems of care that have developed nationally and have gone a long way in proving that parents need to be supported in the care of their children in need rather than being blamed for those needs.

Cultural competence was the other major goal of CASSP. Public systems of care have a higher representation of individuals and families from cultural and ethnic minority groups than does the general population. Yet child guidance had grown in a manner that was essentially color blind. While this had the advantage of trying to be fair and racially neutral, it had the disadvantages of applying the predominant cultural standards to all people, even when it was inappropriate to do so. This has been recognized most prominently in the case of standardized psychological testing, which has proven to be culturally biased against many minority groups. CASSP recognized the need for members of culturally diverse groups to have input into how the system of care is created and how the interventions they and their children receive approach their unique cultural values. At the highest level of cultural competence, child mental health and its systems of care practices need to celebrate cultural differences and use them in the interventions offered to children and families (Cross, Bazron, Dennis, & Isaacs, 1989).

Wraparound Services. CASSP was not only based on the traditions of child guidance and the Joint Commission; it also borrowed heavily from the alternative youth service philosophies of the 1970s. From these, CASSP encompassed the con-

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cepts of wraparound services, which were adopted as the CASSP-oriented intervention. Wraparound is the application of alternative youth service philosophies and practices to children and adolescents with serious emotional disturbance and their families (Katz-Leavy, Lourie, & Dendy, 1992). With wraparound, a team of individuals, including the family, who know a youth well, like him or her, and can see his or her strengths comes together with the youth to plan interventions. This team makes an unconditional commitment to stick with that youth until help is no longer needed. The implication is that the group will work to modify the intervention approach until a successful combination of services is discovered. In order to make this happen, the team explores the youth's strengths and develops interventions that build on them, while at the same time creating interventions aimed at protecting the youth and others from problematic behaviors. The family takes a major role in wraparound planning and caring for the child, and the family's strengths are used as part of the plan. What follows is a truly individualized and flexible planning process and intervention. Thus, wraparound encompasses the alternative service–derived principles of unconditional care, strength-based approaches, individually developed, culturally relevant, and flexible services, along with the CASSP system of care principles of community-based and family-centered services delivered in the context of multiagency systems of care, and gives professionals and families a way to maximize the resources available to them.

Heritage of CASSP. CASSP has had a positive effect on overcoming the forces that have limited the effectiveness of community child mental health and child guidance principles. It has encouraged the multidisciplinary approach, going even further to describe a multiagency approach. It has worked to bring juvenile justice and mental health closer together again in meeting the needs of children and youth with emotional problems and fighting delinquency; it has gone even further by also bringing other agencies, child welfare, and special education together as part of the multiagency system of care. It has helped to create a parent movement that has taken major steps in undermining the concepts of parent blaming; it has gone even further by recognizing the major role that family members must play in the development and running of systems of care, as well as acting as the major resource for their children. It has institutionalized the concepts of cultural competence. It has created a governmental response that has encouraged expansion of the principles of child guidance and the system of care necessary for its application to the most seriously disturbed youngsters; by 1995, it had been noted that all of the states had at least one full-time child mental health specialist at the state level (Davis, Yelton, Katz-Leavy, & Lourie, 1995). In addition, it added the wraparound service philosophy and practice as a new force to move the field ahead.

The concepts of systems of care for children and adolescents with serious emotional disturbance and their families that emerged from CASSP were first applied

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to local service delivery on a large scale in 1989 through the Mental Health Services Program for Youth (MHSPY) of the Robert Wood Johnson Foundation. This program initially funded eight five-year grants for state-local collaborations to provide services based on CASSP principles in a particular community to children and adolescents with serious emotional disturbances and their families (in one instance, the grant affected an entire state). Major contributions of MHSPY include the practical definition of the population in need of an interagency service system, the development of models for organizing and running those systems, and the definition of the role of child psychiatry in the system of care concept.

Other local system of care development projects were started by states themselves without the Robert Wood Johnson support, and by 1992 I was able to identify enough such sites to perform a study of the principles of local system development (Lourie, 1992). The major finding of this study was that the development of a productive local system of care relied most on the cooperation and leadership of several local public children's agencies, such as child welfare, mental health, juvenile justice, and special education. The type of collaborative processes that developed relied on those leaders' accepting a joint mission that followed not just from the CASSP principles but also from the beginning concepts of child guidance (Cole & Poe, 1993).

The CASSP concepts became codified in law in 1992 when Congress, impressed by the success of MHSPY, passed an act that created the Comprehensive Community Mental Health Services for Children and Their Families Program (Children's Services Program) (P.L. 102–321), which has supported the development of systems of care based on the CASSP principles and MHSPY service delivery models across the country. The Children's Services Program, administered by the Center for Mental Health Services, had funded service component development in more than forty-five additional communities by 1999, which are developing system of care approaches (U.S. Department of Health and Human Services, 1999).

The public support of local system of care development concept has not been without some controversy. Although CASSP and its principles have received wide acceptance and acclaim, several researchers have found that some system of care demonstrations have not proven to be more effective than the more traditional services systems (Bickman, Guthrie, & Foster, 1995). Others have argued that the systems so studied were not fully developed systems of care and that the CASSP principles and system of care philosophy are so ingrained in service systems that it is impossible to find a community that has not incorporated some system of care practices and can act as a true control for the purpose of rigorous research design (Friedman & Burns, 1996). Regardless of the controversy, the U.S. Congress continues to support the Child Mental Health Services Initiative at a rate of nearly $80 million a year, the second largest federal mental health program behind the community mental health center block grant program.

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Community mental health as applied to children, adolescents, and their families has endured from its beginnings with the first child guidance concepts and centers. It flourished under Part F of the Community Mental Health Center Program. Today it is alive and well within the system of care concepts and practice that emerged from CASSP and incorporated the alternative youth service principles embodied in wraparound service interventions and other similar concepts and practices. The particulars of the system of care for children and adolescents are the subjects of the chapters that follow.

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