

UNCLAIMED CHILDREN REVISITED:
FOSTERING A CLIMATE TO IMPROVE
CHILDREN'S MENTAL HEALTH



The Twenty-fourth Annual Rosalynn Carter
Symposium on Mental Health Policy

NOVEMBER 20 AND 21, 2008

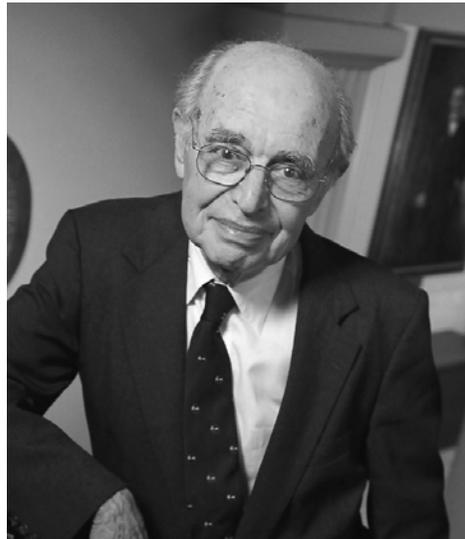
THE
CARTER CENTER



Waging Peace. Fighting Disease. Building Hope.

DEDICATION

To the memory of two colleagues who
devoted their lives to helping children



Dr. Julius Richmond
September 26, 1916 – July 27, 2008



Dr. Jane Knitzer
June 8, 1941 – March 29, 2009

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MENTAL HEALTH PROGRAM

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OPENING REMARKS

Rosalynn Carter

Chair, Carter Center Mental Health Task Force

It has been a quarter century since Dr. Jane Knitzer and the Mailman School of Public Health at Columbia University released the groundbreaking policy report on children's mental health, "Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services." The report documented policy and program disconnects that resulted in children and youth with mental health issues and their families not getting the services they needed. That report along with the rise of family advocacy served as a catalyst to improve service delivery for our most troubled children.

Since then, we have learned so much about the developing brain and made so many advances in treatments for even the youngest children with mental illnesses. But we have failed to implement that knowledge into measurable practical success stories for our children and youth. This is clearly demonstrated in "Unclaimed Children Revisited," a new study that assesses how current mental health policies in all U.S. states and territories respond to the needs of these children and their families.

As the economic downturn worsens and states' mental health systems come under tremendous duress, holding this symposium now is very timely. The current circumstances introduce serious risks for losing the gains we have made over the years, particularly with regard to the most basic safety net that exists for children who have mental illnesses and their families.

This symposium is an opportunity for us to come together to review the challenges we face and explore the opportunities that exist to help these children and youth. The findings of Unclaimed Children Revisited provide us with a comprehensive approach that combines policy and practice in a responsible community-based framework to provide better mental health services for the children and youth in our country.



INTRODUCTION TO KEYNOTE ADDRESS

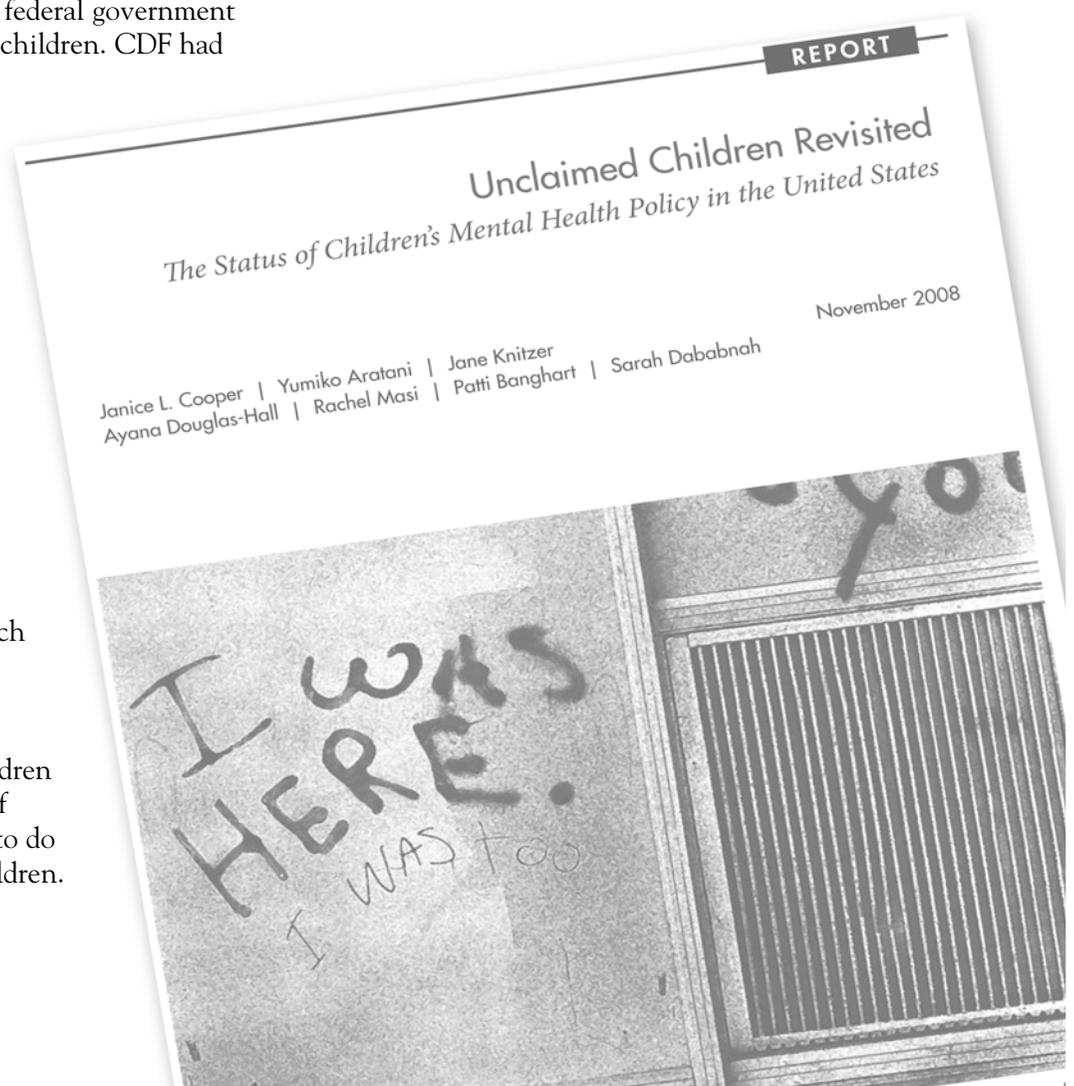
Jane Knitzer, Ed.D.

Director, National Center for Children in Poverty, Mailman School of Public Health, Columbia University

Atireless child advocate, Marian Wright Edelman has trained a network of child advocates through her work over many years directing the Children's Defense Fund (CDF). She has just written another wonderful book, "The Sea Is So Wide and My Boat Is So Small," to inspire all of us to seize the opportunity that we now have with the new presidential administration to advance children's issues and alleviate some of the challenges. She is here today as our keynote speaker because she was the first supporter of "Unclaimed Children" back in 1985.

I will tell you the story of how Unclaimed Children came to be. I read an internal memo that basically said that the federal government knew nothing about these children. CDF had lawsuits in both Texas and New Jersey, finding a pattern of either white kids in New Jersey sent to residential treatment or black kids in Texas sent to residential treatment, often far from home, and there was a major lawsuit. I got really upset about this because I was once trained as a clinical psychologist and said that we ought to do something about it. So Marian said, okay, let's do something about it, at which point I wrote a three-page memo and somehow we got funding for Unclaimed Children. Unclaimed Children was born and all because of Marian who said we have to do something about these children.

When Unclaimed Children came back from the printer, I distinctly remember standing at the steps and saying to Marian and Marylee Allen that there are probably five people in the country who will read this. You can imagine my feelings today. Here we are, and Marian is going to deliver the keynote, kick us off, and get us mobilized. We have all been to too many wonderful meetings where everyone feels good about everything that has been done but, then, look back and it wasn't enough after all. So I hope Marian's speech is the kickoff to get us mobilized. We need a new mental health paradigm for children, and we need to work very hard to get it implemented.



KEYNOTE ADDRESS

Marian Wright Edelman

Founder and President, Children's Defense Fund

Now it is time to build the transforming movement that is going to change the priorities of our nation to understand that investing in children is the most important thing we can do. I hope that you can constantly renew your mission after so many decades in the

It is so much easier to raise and to build healthy children than to repair broken men and women.

wilderness, understanding that the real future of America depends on our investment in every child. If we don't begin to change our paradigms and focus on prevention and early intervention, it is going to be our moral and economic Achilles' heel. You are the most important people in the world, and I thank you, and I am honored to be here with you.

Jane Knitzer proposed Unclaimed Children in the early 1980s and gave me the honor of simply enabling her to do what she saw needed to be done. She saw children and adolescents who were without the services or treatment they needed, and recognized the failure of public responsibility to meet those needs. More and more of us fell in behind her to lend a hand to these children who are the most vulnerable in our many systems.

And so Unclaimed Children came into being. She understood that it was important for us all to begin to work earlier and earlier with children in

their homes, in Head Start programs, in early child development programs, in schools, and to reach out to younger and younger children. Instinctively, she seems to understand what Frederick Douglass wrote many, many years ago, that it is so much easier to raise and to build healthy children than to repair broken men and women.

Children do not come in pieces. They come in families, and families come in communities. Communities are affected by the culture and by public policies. We have to have multiple strategies. We have to break down all these silos, address the needs of the whole child, and push forward with persistence and passion. Jane Knitzer's ability to keep the faces of real children before us, front and center, to know what is happening in the communities, and to marry fact, data, and the most effective policies and practices make her such a wonderful and effective advocate for some of the most vulnerable children and youth.

I am very sad that we are revisiting the same concerns over and over again in this country. It is hard work, as all of you who are working in the vineyards know. But we will keep at it until we win because it is not an option to lose. Family members, youth, mental health professionals, staff, directors of multiple programs, and child-serving agencies are continuing to work hard for improved and increased mental health services for children of all ages and races, ethnicities, and income. Finally, we have parity for mental health insurance. Now we need the coverage and the infrastructure to make it real and well funded. That is our chore.

"Unclaimed Children" Background

In Unclaimed Children, Jane and CDF examined why troubled children and adolescents were not getting what they needed, and what responsible officials, concerned advocates, and the public at large could do about it. We need to keep Unclaimed Children Revisited and Unclaimed Children front and center.



Marian Wright Edelman

As we enter this next stage of transformation, remember that, in 1982, only a handful of states were beginning to meet their service responsibility to our children with mental health needs. Only one state was systematically trying to close down psychiatric institutions for children and replace them with less restrictive, community-based services. Only about half the states differentiated between adults and children and voluntarily admitted minors to psychiatric hospitals; only six of those routinely mandated child-specific reviews once children were in hospitals.

In some states, children and adolescents were still routinely placed on adult wards of state hospitals. Only seven state mental health departments had taken even the first limited steps to create a system of care for children and adolescents that included a full range of mental health services. Even fewer of those were reaching across systems.

The SSI programs for disabled children did not yet exist. At the time of the Unclaimed Children report, just over 200,000 blind and disabled children received aid under the SSI programs and only a few of them were children with severe emotional illness.

Medicaid and Early Periodic Screening Diagnosis, and Treatment program did not require states to provide mental health treatment for problems they found through developmental assessments. The requirement that all medically necessary treatment be provided was added later. Enforcing it, however, was a whole different can of worms.

When Unclaimed Children was published, children and adolescents were specifically excluded from the National Institute of Mental Health's community support program for people with chronic mental illnesses. And there was no Children's Mental

Health Services Plan. In Unclaimed Children, we highlighted parents supporting children, such as a group in Kansas City, Mo., run by and for parents whose children had emotional problems. One of those parents, Barbara Huff, held the first Federation for Children's Mental Health meeting a year or two later. There was no mention of engaging youth, either in their own treatment or in advocating for increased resources for those with similar needs. Now there is a national youth movement, an effort by those who have been involved in systems, to motivate others through voices of experience. We have to strengthen them and connect them so that our voice becomes irresistible.

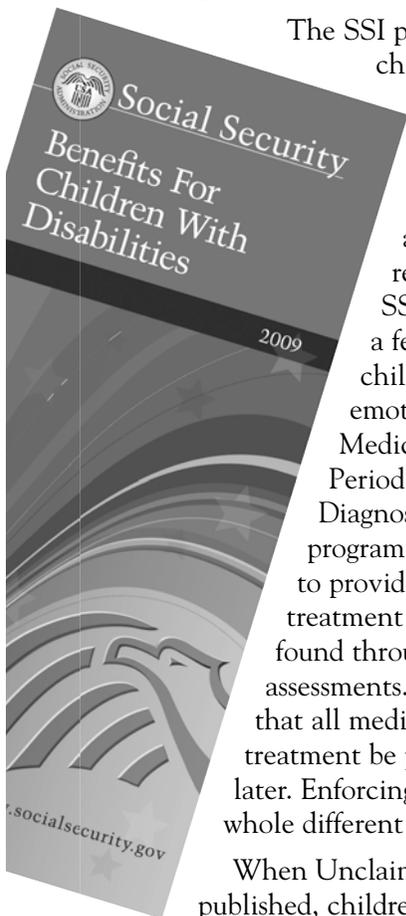
Current Climate

It is easy to get caught up in the crisis of the day, month, or year and never reflect on the progress. There are so many things that we take for granted and could not have envisioned more than 20 years ago. We know so much more now than we did then. Now, we have research on early brain development, on the value of working across systems to maximize the benefits of interventions for children, on ways children benefit from their parents' mental health, and on substance abuse problems, as well as on the benefits of early intervention and prevention, and the long-term fiscal and social implications of not intervening.

Unclaimed Children said virtually nothing about substance abuse and its challenges for both youth and their parents today. The study focused on children and youth with the most serious needs and, at the time, this attention was long overdue. But, there was no attention given to the social and emotional development of our youngest children. We know more today than 20 years ago about the impact of race and poverty on children's access to the services and supports they need. And we talk about the importance of competencies—racially, culturally, and linguistically—and the connections that we too seldom have made and put into place.

Unclaimed Children focused on treating individual illnesses, disorders, and disturbances, rather than on the need for a public health approach to treatment. With the new report, Unclaimed Children Revisited, it is the responsibility of all of us to help ensure a level playing

The test of the morality of a society is how it treats its children.



field for all of the children in America. So many children are born into our rich nation to an unlevel playing field with two, three, or four or more strikes against them: low birth weight and substance-abusing poor or single mothers who have never been taught how to parent or have support in their parenting. These children never, ever get on the track to successful adulthood. Instead, they are funneled off into what we call a cradle-to-prison-to-death pipeline. That is something that we need to change, and we must change it by building a very powerful movement for children, helping all in America to understand that every step we take to improve the lives of children improves the lives of us all.

I often quote Dietrich Bonhoeffer, the great Protestant German theologian, who believed the test of the morality of a society is how it treats its children.

We must not stop until we help America pass that test, which it currently flunks every hour of every day:

- Every 33 seconds, we let a child be abused or neglected.
- Every 36 seconds, we let a child be born without health insurance.
- Every 39 seconds, a child has a child; we can fill up the city of Atlanta with children having children each year.
- Every three hours we let a child be killed by firearms, and many of our children are growing up in war zones all over America.

Currently, a child drops out of school every 10 seconds. A majority—65 percent—of all children of all races and all income groups cannot read at grade level in fourth, eighth, and 12th grades, and over 80 percent of our black and Hispanic children cannot read at grade level or do math at grade level. The numbers get worse as they get older. What is a child going to do if he can't read and compute in this globalizing economy? It is a sentence to economic death, and it is fueling that cradle-to-prison pipeline. A 7-year-old black boy



has a one-in-three chance of going to prison in his lifetime; a Hispanic boy a one-in-six chance; a white boy and black girl a one-in-17 chance of going to prison. This is a personal tragedy, a community tragedy, and it is an impending national catastrophe. We are the world's leading jailer with 7.3 million people in jail, on probation, or on parole.

If we don't do something about this pipeline, we're going to undo the hard-earned progress of the last 40 years that Dr. King and the Civil Rights Movement struggled to achieve. We have the largest disparity between rich and poor we have ever had. There are 13 million poor children today; there were 11 million when Dr. King died. The majority of them are in working families. Nine million children have no health insurance. A majority of our states are spending three times more per prisoner than per public school pupil. I cannot think of a worse investment policy. Our job is to change that.

What We Need to Do

We must all speak out together against policies of criminalizing children at younger and younger ages. Sometimes, I think that we adults have lost our minds, such as the zero-tolerance drug policies that have filled up our prisons with disparate sentencing between crack and cocaine. Over 2 million in prison today are there for nonviolent offenses.

We are seeing zero-tolerance school discipline policies where 5- and 6-year-olds are expelled from school and police called in to handcuff 6-, 7-, and 8-year-olds and take them off for things that used to be settled in the principal's office. We have got to stop this criminalization of children and the criminalization of poverty. And, we must begin to substitute our current paradigm of punishment as a first resort with more prevention and early intervention, which is cost-effective but also designed to help our children get what they need.

Child poverty. Our top priority must be ending child poverty. We have the highest relative rate of child poverty among industrialized nations. Since the nations of the world have set out linear development goals by 2015, why don't we, as the so-called most developed nation or the world

leader, have our own millennial development goal and say we are going to end child poverty beginning with extreme child poverty, which is going to grow in the aftermath. We have 5.8 million children living in extreme poverty and those numbers are going to get

worse in light of this economic debacle that we face. That's unworthy of us as a nation.

Universal health insurance. We should have a child health bill that says all children will be covered—all of them, not some. God did not make two classes of children. All children, whoever they are in this country, ought to get comprehensive benefit packages that are guaranteed, that are not subject to the lottery of geography. Children should be able to get what they need, and it should be portable wherever they go. These comprehensive and guaranteed benefits include mental and dental health and prenatal care for every mother. We are the only industrialized country that does not provide prenatal care for its mothers, and it should be simple and automatic.

Early childhood programs. We have to have high-quality early childhood development programs and make them accessible to every child and every family. And, we have to make sure that children do learn how to read. I don't know what it is about us that we can send spaceships to Mars and people to the moon, and we cannot figure out how to teach children to read by fourth grade.

Something is wrong there. We need to speak up and challenge and make sure that every child can realize his full potential in school, that we strengthen our schools but, also, that children are ready to come to school. The fact that Early Head Start still reaches only 3 percent of the eligible children is ridiculous. We really need to try to put together a coherent system that treats

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the needs of the whole child and expand protection of children through prevention and specialized treatment services for children and their parents.

Detention and incarceration. We must reduce detention and incarceration by changing the paradigm to prevention and early intervention, and accelerating reforms of juvenile justice policy at all levels to ensure that young people in the juvenile justice system get the integrated services they need to put them on a sustained path to a successful adulthood. Recently, I visited two juvenile facilities, one in Los Angeles, one of the more enlightened ones, and did a reading group with a group of 20 young people, largely black and Hispanic. After the reading period was over, one asked, “What are you most afraid of?” One little boy said that he worried about how his mother was going to survive or react when he died.

Even more recently, I went to Missouri with a delegation from New York state’s juvenile justice and child welfare system to see Mark Stewart’s program. There, in their most secured detention facility, which felt like a home, you saw a different paradigm of caring staff who respected and

If you are going to teach, then love children. If you do not love children, get out of the classroom.

loved children. I keep saying: I don’t care how many degrees you have. If you do not love and respect children, it is not going to work. If you

are going to teach, then love children. If you do not love children, get out of the classroom.

It felt so wonderful to be in an institution where the culture was there to support, empower, respect, and love children. The children know that they run the institution and the staff was simply there to supervise and guide them when they needed it. It took Mark Stewart 20 years to change that system and to build the political support for it. Nothing is easy; nothing comes quickly. In the middle of this experience, I realized that this is just good parenting. They are getting what they never got anywhere and they are being prepared to go back

out to be a part of the community, be connected to the community, and have a sense of their responsibility to each other. Their recidivism rate with these small, therapeutic houses is about 7 percent. And it is costing less money than when they had these big, secure detention facilities.

Conclusion

We know what to do, and you and I have to take all these best practices and put them into place, put them into policy, and make what works available to all of our children. It is absolutely unacceptable that the single universal child policy in the United States of America is a jail or a detention cell after a child gets into trouble.

We have to have universal policies that say you are going to get high-quality, comprehensive health care when you are born, and high-quality, early education to get ready for school. You are going to have first-rate after-school programs because children are in schools only 17 percent of the time. We are going to make sure that we produce the next generation of healthy children.

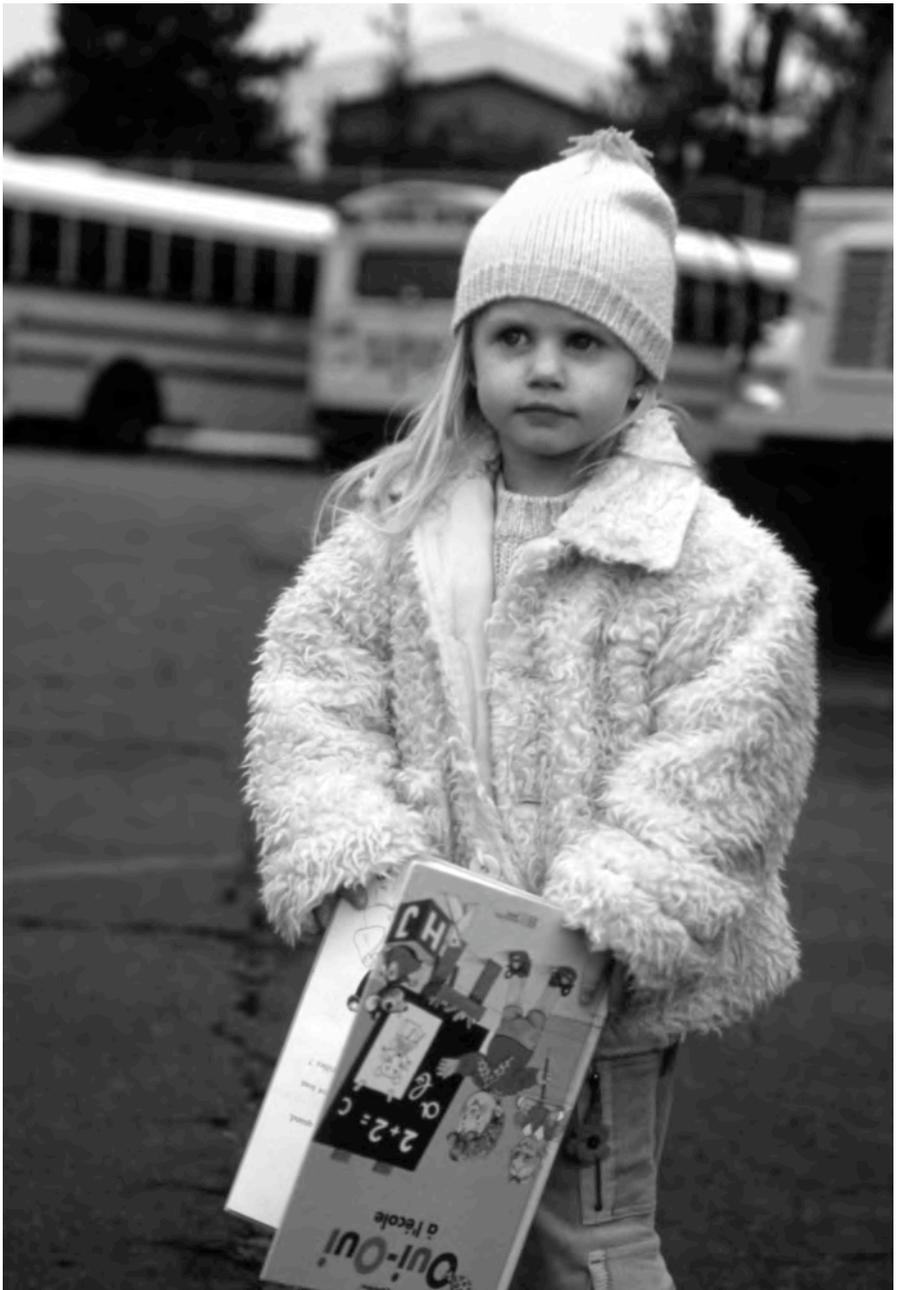
Now, we have made one other little success this year. Congress passed the Fostering Connections to Success and Increasing Adoptions Act, and we need to make sure that it is implemented in all of our states. There are a lot of things that we can do in redirecting Medicaid funding. Most of our funding

incentives go the wrong way, but I hope we can change that paradigm into prevention and early intervention.

We must continue to believe in miracles, but then we must continue to organize to make those miracles real. David Ben-Gurion said a long time ago that a man or woman who does not believe in miracles is not a realist. I think we are on the brink of something extraordinary, but we have unprecedented problems: climate change, energy changes, an economy that is absolutely on the brink of collapse, and two wars. We have to figure out how we do not let children and the poor get lost. We have got to band together, be strategic, ask for one or two big system changes in investments each year.

A good president or a new Congress is only going to be as good as the citizens outside demanding it. A. Philip Randolph visited President Franklin Roosevelt in the White House and told him about the needs of the black community, about the need for jobs and to end discrimination. President Roosevelt listened with great, great sympathy and, at the end of Randolph's presentation, the president said, "You know I agree with everything you have said, Phil. Now you go out and make me do it." That is the reality of politics.

We must organize for children. We must get over it being about us, or about our organization, or our discipline, or about the way we have always done it, and come together to put children at the center of our concern. If we can change things for children, we will end up changing things for everybody. If the child is safe, everybody is safe, but we cannot help children effectively unless we help their families, change their schools, deal with the community culture, and deal with the external voices. This is our time, and I hope that we will seize it fully for the benefit of ourselves, our children, and our country.



POLICY RESPONSE

Jane Knitzer, Ed.D.

Director, National Center for Children in Poverty, Mailman School of Public Health, Columbia University

Social change equals knowledge plus social strategies plus political will. We are about to share a new body of knowledge. But, more importantly, I hope to begin a dialogue about a new set of social strategies for children's mental health that can help us collectively, not just to change the paradigm to a public health, developmentally appropriate paradigm, but to institutionalize it in policy and practice. That is the challenge that we face, and we need these strategies to build political will so that something significant can happen over the next four years.

My task is to give you an overview of the findings of *Unclaimed Children Revisited*. First, I want you to know that this report was really done by Janice Cooper and her team. So let me talk about what we did find. The mission of the National Center for Children in Poverty (NCCP) is to promote the security, health, and well-being of America's low-income children and families—no small agenda. We focus not just on children's mental health but also on improved family economic security, which is the precursor of all good mental health. And we have a very strong early childhood agenda.

Today, I am going to set the context. Since 1982, an explosion of knowledge has occurred about the root causes of mental illnesses, and about psychopharmacology, effective prevention, early intervention, and treatment strategies.

It is time we did what our rhetoric says we need to do.

We knew nothing about evidence-based practice in 1982. But there has been no major policy study to see how this new knowledge has been incorporated into service and practice. That is why we thought it was important to do *Unclaimed Children Revisited*.

The reports continue to document growing unmet needs and growing crises across the age groups in children's behavioral and mental health. The overall goal for *Unclaimed Children Revisited* was finding best practice and policy nuggets that we could take to inform the next generation of legislative, administrative, and

executive reforms. In the face of all the constraints, how are states working to provide access to prevention, early intervention, and treatment across the age span for children? How are they working to:

- infuse empirically supported practice in the service delivery system?
- implement intentional practice?
- improve family responsiveness and cultural and linguistic competence?
- spend smarter and more efficiently through infrastructure and fiscal and accountability measures?

Today is the first day to outline the next-generation children's mental health system and, I have to say, to strengthen the federal framework to move to a real public health agenda for children's mental health. It is time we did what our rhetoric says we need to do.

Unclaimed Children Revisited turned out to be a massive undertaking involving one major national study and a state survey of children's mental health directors. All 50 states responded. We conducted four substudies: California case study looking at 11 California counties; Michigan case study; survey on cultural and linguistic competence; and a survey of mental health associations, which we actually did in the original *Unclaimed Children*. So there is a massive amount of data to synthesize and begin to try to tell a coherent story.

We asked very specific core questions and the report is organized around their responses:

- How well are states serving children and youth with mental health conditions?
- How are states moving toward a child mental health system guided by a public health approach?
- How are states addressing the age-appropriate needs of children and youth?
- How are states improving systems and service delivery for children and youth with serious emotional disorders and their families?

- How are mental health practices across the age span guided by evidence of effectiveness?
- How well are states meeting the need for family and youth responsive services and culturally and linguistically competent services?
- How do states improve service? This is really important. Through infrastructure-related supports (such as information technology), we are so far behind the eight ball on using some of the tools of a system infrastructure for children's mental health, fiscal policy, and accountability measures. You cannot institutionalize a system unless you have some of these pieces in place.
- What policy opportunities and barriers do states face as they try to improve the service system?

Results from States

Forty-one states reported serving some children well who had serious, complex needs. Twelve states said there were no children that they served well, which was remarkably honest. The state mental health directors were very helpful in developing the final questionnaire. We can't vouch fully for the honesty of everything we heard, but they were certainly honest in this one.

Given all the talk, the New Freedom Commission Report, and focusing on children before they get to the deep end on the way from the cradle to the prison, one of the interesting findings was that no state identified children (and youth at risk) as the ones that they served well or poorly. To me, that says those children aren't really on the radar screen for the narrow children's mental health system.

States report that they are moving toward a developmentally appropriate public health framework, but progress is slow. When you dig a little bit deeper, though, there really is no shared vision for what this means or for what states should be doing. What we have is some states saying, "Well, we are doing this because we are focusing on prevention and early intervention"; some states saying, "We are doing this because we are trying to balance the array of services better

for seriously emotionally disturbed kids"; and most of the states saying, "We are trying to do this by doing a little bit of everything."

Right now, states vary in their efforts to meet the mental health needs of all children in a developmentally age-appropriate manner. Only seven states reported consistent support and funding for young children, school-aged children, and youth across the age span. It is interesting because there were seven states in the original Unclaimed Children that reported efforts to build systems of care.

Findings

Forty-four states reported one or more early childhood initiatives. Thirty-seven states reported that the children's mental health authority actually funded early childhood mental health services directly, which is a positive thing. But in only half of the states is there at least one initiative statewide, and statewide can have a loose definition! It does not necessarily mean penetrating all the geographic areas of the state.

The kinds of initiatives that states are reporting make sense given the research. Twenty-six states reported that early childhood mental health consultations are growing, and they reported providing reimbursement for social and emotional screening tools—very important. One of the things that has boggled my mind since 1982 is the lack of interaction between systems for the adults who are in the adult mental health system. Very often, no one has asked if these people are parents.

Eight states reported treating parental depression. At some point soon, the Institute of Medicine will come out with a new report, thanks in large part to Dr. William Beardslee's leadership, that looks at parental depression and child development outcomes and parental practices. It is a landmark effort to talk about a family-focused system for adult depression, which we do not have and which we need.

Only seven states reported consistent support and funding for young children, school-aged children, and youth across the age span.

Core findings for school-aged children

Forty-seven states reported one or more initiatives for school-aged children and youth. Only half of these states have one initiative statewide. The theme is: yes, we do it, but no, we do not do it statewide. School-aged, school-based initiatives include positive behavioral supports, school-based mental health and health clinics, and partnerships with the Department of Education. We need concrete and schoolwide efforts around social and emotional climate changing and some targeted supports for youth with serious emotional disturbance. We have the right components, but the right components are not necessarily all in the same school districts and, of course, that is what we all need for comprehensive, school-based leadership from children's mental health.

Core findings for youth

Forty-four states reported initiatives for youth and young adults. Sixty percent of the states report one or more of these statewide. The initiatives include health insurance or other

social supports, state guardianship after age 18, partnerships for jobs, and addressing SSI provisions that discourage work.

Serious mental health conditions

No surprise here. All states reported that they have incorporated systems of care philosophy, but only seven states reported anything in legislation and 11 states in regulation. That is 26 years after the Community Mental Health Service Program. We can do better than that. State systems still show overreliance on residential care, even in the system of care sites, and the findings from the system of care efforts have been mixed.

Evidence-based practice

Here we have a new set of knowledge, a new set of tools. All states reported promoting evidence-based practice, but only 19 states reported that they require support or promote specific evidence-based practices statewide. Twelve states reported legislative or administrative mandates, and 60 percent of the state advocates report



knowledge of their state efforts. That's true of state advocates; it is not so true of family and youth.

Family and youth voice

Almost all of the states reported efforts to strengthen the family and youth voice in policy. Again, that's part of our rhetoric, part of our mantra. The proof of the pudding is in what happens concretely and in 15 states, which was a significant number of those who reported, mental health advocates report being dissatisfied with the depth of the involvement. Family advocates at NCCP took a look at some of this and said, "You're being much too charitable to the states." And we said, "But we have to track what the states are doing." However, it is always a good check to talk to the advocates and see what they think the states are really doing.

States, however, are increasingly funding services delivered by youth and families. One of the most exciting impacts that Unclaimed Children played a little role in was starting the family advocacy movement. Families whose children had serious problems were in the closet. They were not organized as advocates and so the growth of the movement for families and, now, for youth is one of the truly powerful changes that has happened over the last 26 years.

Culturally and linguistically responsive services

Twenty-seven states reported on policies that support cultural and linguistic competencies. But again, when you look at what this means, eight states have strategic plans to assess and improve in an ongoing way, and only five states reported a mix of intentional steps. So what you have is a lot of states reporting one or two things but not a critical mass set of strategies.

Infrastructure and accountability

States have mixed records in efforts to improve service delivery through infrastructure, and we have had very few incentives in federal leadership to help the states do this. Obviously, that is one of our challenges. Only two states report what they call an advanced infrastructure to support data-driven services. It is really important

that we begin to use data in a different way if we are ever going to have a really accountable children's mental health system.

Fifteen states described attention to outcome-driven practices as rudimentary. Forty-one reported they share data for community planning, but in at least 10 states the advocates said they did not know much about it. Clearly, the data are in the eyes of the beholder, but very important in setting a road map.

Financing

Only 27 states reported on their mental health budgets for children, and only 11 had data across systems. The cross systems piece is very important. The vision for Child and Adolescent Service System Program (CAASP) was that all the child-serving systems would come together. But in fact, almost every federal agency has its own system of care, as you all know if you sit at the community or state level and serve on multiple advisory groups.

Medicaid is problematic. If you asked me, "What are the two things we need to fix?" One would be the federal legislative framework and the other would be Medicaid. We do not spend smartly on children's mental health. We do not use wisely the considerable resources that we spend, and Medicaid is a significant part of the problem. Only 19 states reported using the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for behavioral screening, although it is mandated. Only 16 states reported that they permit reimbursement for young children regardless of diagnosis. Twenty-nine states require diagnosis even for participating in mental health consultation!

Some states are using Medicaid to pay for family- and youth-guided services. Medicaid is all over the map, too. It is very difficult to pay for evidence-based practices, so, on the one hand, all of us are cheerleading for evidence-based

It is really important that we begin to use data in a different way if we are ever going to have a really accountable children's mental health system.

We do not use wisely the considerable resources that we spend, and Medicaid is a significant part of the problem.

practices, and, on the other, we have Medicaid saying you cannot bundle those kinds of services and pay for all the core components that lead to evidence-based practice. So we have a real disconnect between the knowledge and our fiscal policies. That is one of the central challenges that we face, and, frankly, I think we have ducked it for a long time.

Twenty-one states make Medicaid decisions in consultation with mental health; 12 states make Medicaid decisions without even involving mental health. Only four states reported that mental health makes Medicaid decisions. So, in effect, what you have is a system that says here is the substance of the knowledge and here is where we're making fiscal decisions. I do not know what gets the award for dumb and dumber but that does not sound right.

Six States: The Case for Best Practices

States are trying to implement innovative best-policy practices and that was our commitment in the beginning for this report. Let me quickly share with you six states that we think have really put in place, or are trying to put in place, things that could set the stage for how we might want to

craft state or federal legislation. They also offer a guide as to how we might think about building a real incentivized system, with the incentives going for the right, not the wrong, things.

California has dedicated prevention and early intervention money through the Mental Health Services Act.

Colorado has been working on cultural competency, and they are the only state as far as we know. They have also worked on custody relinquishment using SSI and tobacco money, as have a few other states. The fact that we have not solved the custody relinquishment problem, which I wrote about in Unclaimed Children, is so immoral in my view that I do not even have words for it.

Indiana is developing a pay-for-performance system that is actually tracking functional outcomes. Is the child in school? Is the child in juvenile justice? Is the child in a less-restrictive setting?

Michigan is focusing on outcome-based management and is trying to move the system in that direction.

New York has seriously expanded, to the tune of \$62 million, community-based service capacity and a program called Clinic Plus.

Washington state has enacted comprehensive cross-age legislation that has a variety of interesting components. They focus on outcomes. They have a center for evidence-based practice that is a resource to the states, which a number of states have separately. They have waived requirements for children to have diagnoses, and they are actually training families and youth on evidence-based practice, which is one of the real gaps that we noted.

Looking Ahead

The vision for the next generation includes the following:

Flexible funding to incorporate knowledge. Right now, you know the effort it takes to change one Medicaid provision, which is not in keeping with what we know.

Attention to children with mental health conditions and those at risk. Unless we move the system to deal with children at risk, we will be ignoring cumulative developmental psychopathology and psychology knowledge and shooting ourselves in the foot because we are not doing all that well with the deep-end kids and we need to move ahead.

Dedicated funds for prevention and early intervention. States need funds they can count on, that are not going to go away, and that are part of the children's mental health and other budgets.

Increased supports for parenting and parent support. We do not have a family-focused children's mental health system, which is mind-boggling.

Implementation of a system of care values and incentives to reduce disparities. Commonwealth Fund has been doing some very interesting work on disparities. Go to the Web site (<http://www.commonwealthfund.org>) to see the series of articles it put together. The issues are not around mental health or early childhood, but the issues are the same tough issues.

We have a real disconnect between the knowledge and our fiscal policies.

Use of data. We have to have a system that is data driven; we have to have requirements for cross-system partnerships, and for integrated service delivery systems.

Supportive financing and infrastructure incentives, strong federal leadership, and a federal legislative framework. I am happy to say I think we have some new opportunities.

Moving forward, let us begin to build a consensus in the same way we did around Community Mental Health Service Program: crafting a legislative framework that supports emerging knowledge and best practices, rather than undermining it; ensuring that the Centers for Medicare and Medicaid Services develops a comprehensive strategy to use Medicaid in a wise way; and seizing new opportunities. Paraphrasing Marian, I charge all of us to be miracle-making realists as we go forward toward a new generation of children’s mental health.



RESPONDENTS

Moderator, Larke Huang, Ph.D.

Senior Adviser to the Administrator, Substance Abuse and Mental Health Services Administration

When the stars have aligned, and today I mean that both figuratively and literally, it is a sign of really new opportunities. We have a new administration coming with a new energy, renewed optimism, an exciting agenda for change. However, as a country, we are experiencing an economic crisis of tremendous magnitude, the depths of which we may not have fully experienced yet. Historically, in periods of severe economic downturn, children, children’s services, and child and family well-being bear the brunt. Domestic violence, suicide, alcoholism, depression—all of those kinds of risks in children’s lives increase. So, more than ever, we have a sense of urgency for children’s mental health and an imperative to build on what we have learned over the past 25 years since Unclaimed Children.

We need to rethink our focus and ask, How can we better meet the needs of children with mental health conditions and children who are at risk? SAMHSA’s recent leadership discussions have asked, How are we going to meet our treatment gap? We do an annual survey of 75,000 households, and there is a constant trend of increasing numbers of young people, 18- to 24-year-olds, who meet the criteria for depression or substance use disorders to the tune of about 10.9 million youth, and 90 percent of them don’t ever come in contact with services. Of those who do seek services—7 to 10 percent—only a small proportion ever connect with services or any kind of support.

We are thinking we really need to move upstream. The way our mental health system is set up, with our resources, we are not able to, and most likely won't ever, meet the needs of youth and families and their communities.

I have been on detail to the Centers for Disease Control and Prevention (CDC). This has been an effort between SAMHSA and CDC, within the Department of Health and Human Services, to look at how we can better collaborate in terms of our programs, our policies, our initiatives around health, and look at mental health as a critical piece of overall health and well-being.

CDC is spearheading a move that involves a wide range of federal, public, and private partners and the technology sphere. We have Google Health and IBM involved in the Healthiest Nation Alliance to look at what is necessary to improve the public's health. Even though we spend \$1 trillion on our health care delivery system, our indicators rank us very low in terms of health across developed countries. Something is not working.

Traditionally, we understand public health as early intervention and promotion, but we are also looking at social deterrents and realizing that, in many policies that are not initially health-focused policies—economic, educational, transportation, employment, income support—all of those policies play a role in children's health and mental health.

At the CDC, we were looking at alcohol policies. The initial intent was to look at how policies around alcohol may have an impact on underage drinking. Ten to 15 states had raised the alcohol tax 1 percent on beer, or 5 cents more per gallon. That tax increase, that small tax policy, significantly decreased the number of children's deaths by maltreatment. It also significantly reduced the number of substantiated cases of child abuse. Part of this effort is to look at our policies and recognize that there are health and mental health indicators in them. I'm excited about how we are going to look at children's mental health in this country.



Patrick Tolan, Ph.D.

Director, Institute for Juvenile Research, Department of Psychiatry, University of Illinois at Chicago

I am the director of the Institute for Juvenile Research (IJR), which is a large center in Chicago. It was started about 100 years ago, when the first idea of studying children's development—to think about what to do for them—was coming out of Jane Addams' work and the work of amazing women at Hull House.

IJR started with this idea: Science ought to guide what we think about and do for children. It should not be just theorizing, and it should not just be about our hearts, about caring for children. I am going to take an audacious step here and disagree a little bit with Ms. Edelman in the sense that I do not know that this is about loving children. I worry that, sometimes, that undercuts us. It is about the idea that science is the best way to try and understand what we should do and also understand if our best instincts are wrong. That has been guiding us for 100 years.

As Marian Wright Edelman said, children come in packages. They don't come just with symptoms; they come with families; they live in communities. This is a principle of the institute. Its history reads like the history of child mental health in many ways. The views go back and forth: Is all mental illness genetic, for example, or is all mental illness environment? One can see progress in IJR noting that it is a lot more complicated than we thought, that increasing elaboration of understanding is the goal, but still to keep in mind that this is an ecological perspective. That guides us in what we do there.

We now have 50 people working and talking, from molecular genetics to services research, about how we ought to be thinking about children's mental health. And it has changed the way all of us think about it. Over the last five years, one of the things IJR and I (in other forums) have been trying to talk about is that we do not have to spend a lot more time debating about what we should be doing. The surgeon general's report on mental health can guide us; it is a blueprint. Let us follow it and figure out how to do what it says is needed. Along that view, we need to think about four areas that we all know are interrelated but are distinct areas in which we can make a difference:

- promotion of mental health
- help for mental health care and health needs in normal development and managing of children
- prevention for high-risk populations
- treatment for children with a mental illness and their families

We need to quit debating which one is most important to prioritize. One is not more important than the other. If we have the best daycare in the world, it is not going to get rid of schizophrenia. If we come up with the best

We need to watch for people who are looking to get in front of a parade. Are they going to stay here even after the crowd leaves?

understanding of the basis of schizophrenia, we are not going to get rid of a lot of children's mental health problems. And, as we continue to fight about that among ourselves, in some ways, we are going to undercut ourselves.

There is a saying: The perfect is the enemy of the good. In our advocacy, we are looking for the perfect model of mental health care, and for mental health and children to be the priority for others. It just does not sound like it is going to happen.

We might not want to wait for that revolution to try to get this agenda out there. In fact, we might want to try and understand why it is not on the front page of others' list of things to take care of. My guess is that it is because there are very few people who are not in favor of helping children. Saying this is important is not a very persuasive argument and this is where this "love" idea is starting to concern me. We need to find more persuasive arguments for our agenda to be more of a "people's agenda." We also need to look at our part of the problem.

Most of the educational standards in our training programs and ways we run our practices are outdated. We are training people for practice in the 1980s and 1990s. By the time they get out, typically, they are scientifically incorrect about

what are the best practices. We need to start holding our own professionals much more accountable about that than we do.

We also need to watch for people who are looking to get in front of a parade. Very regularly there are movements within a profession like ours to try to get financial and political resources focused on child mental health. When this occurs, there are people who will take this up and argue for it. They love leading the parade. However, I have found that they seem to disappear as soon as the money and attention disappear. Then you can find them in front of another parade. The problem that this parade leading creates is that conversation gets smaller and smaller, only among and about people who are “child advocates.” It is really not a conversation about how we move forward; it is a conversation about who gets credit for it. And so I think it is good for us to start to get a little suspicious about people who are quick to want to lend their name to these things, and to think more carefully about this: Are they going to stay here even after the crowd leaves?

Last, we need to look at this sentimentality about children, that children’s mental health is something we should do because we love children. Almost always, I find that, when talking with those who can do something, this sentiment is followed with a phrase about why he/she/they cannot do anything about it. It is as though by saying this, they can be pardoned for doing nothing.

There is probably much more powerful science, much more powerful economic calculations that can be done, and much more powerful organizational and political issues that we can argue for this. These can be the basis for my main point: It is that our efforts to affect child mental health should not be about being virtuous for caring about children. It should be about what the problems in child mental health and unrealized potential cost us, what it does to our economy, what it does to our society, what it does to our health and our education. That is where I would suggest that we go, that we use the scientific route rather than arguing for our humanity and our great care for children.

Renata J. Henry, M.Ed.

Deputy Secretary for Behavioral Health and Disabilities, Maryland Department of Health and Mental Hygiene

I am going to speak very briefly about this issue from a state perspective. After working in three states and leading an organization that represents state mental health program directors, and after 30-something years in the field, the very first thing I want to say is “Yea,” when I hear that all 50 state directors responded.

Issues in Pockets of Excellence

All the states are doing something; no state is doing everything. There are indeed pockets of excellence that exist throughout this country, so we know that there are models that we can

replicate. I always pay attention to the core things that these pockets of excellence have so that, when I am in a state leadership position, I can then look and say, “Okay, if I want to

expand this excellence, what are some of the things that I must have?” Clearly, where excellence exists, there is excellent leadership at the top. Top leadership, usually at the governor’s level, has made a commitment to children’s mental health and cooperation among child-serving systems.

Issue 1: Teamwork

In Maryland, the governor has convened the Children’s Cabinet, bringing together all the cabinet secretaries who are responsible for child-serving systems, family advocates, providers, and types like that. The governor made some dollars available but, more importantly, said we are going to work together. A recent acquisition of a system-of-care grant that is going to focus specifically on foster care is one of the outcomes of that kind of work.

Clearly, where excellence exists, there is excellent leadership at the top.

Issue 2: Partnerships

The other thing I noticed about pockets of excellence is that they usually have some kind of good partnership with academia and with researchers. Evaluation goes on. There is a real attempt at trying to educate and train the workforce and bring up that level of expertise. The one caveat that I always say to researchers is how long it takes to get into the field. Whatever we do, we are going to have to reduce that gap. I call on those of you who are researchers to help us understand how to move evidence-based practice into the field much quicker and in a much more effective way.

Again, I will use Maryland as an example. We have a partnership with the University of Maryland, the Mental Health Institute on Evidence-Based Practice. Its sole purpose is to try and ensure that those involved in working with children be in the children's mental health system, in the school system, and in the child care system, and are getting the knowledge that they need to do their jobs better.

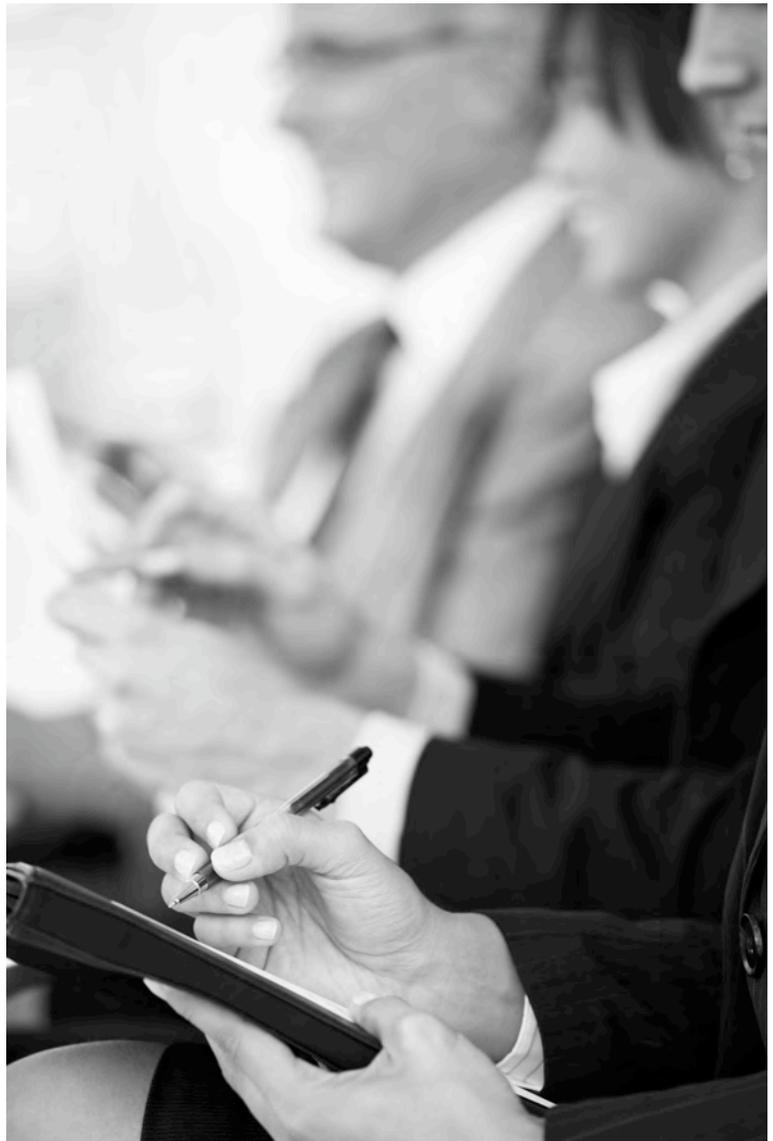
Issue 3: Cross-system Collaboration

There is clearly a focus on cross-system collaboration in pockets of excellence. That goes without saying. I know we are focusing on mental health, but we cannot just focus on mental health without looking at the other systems: substance abuse, developmental disabilities, Medicaid, and juvenile justice, which are the common suspects.

Issue 4: Silos

Finally, efforts have been made to address the issues of silos and of how we are going to fund these initiatives. We have figured out ways to work through the Medicaid dilemma. We have figured out ways to work through the block grant dilemmas. We have figured out ways to use money that comes down from the state side. We have figured out how to work with waivers maximizing Medicaid. How do we manage and work with the managed care organizations?

I look at this as the glass being half full in the sense that we do know what works because there are things that are working out there, although not nearly enough, not as they should be. But we



do know what works, so we can set a research agenda with academia in terms of how to move forward.

Barriers

I would be remiss as a state leader if I did not talk about some of the real barriers that states are facing. I think all of us know them, but let me remind you. Every state is facing critical and large cuts in their budgets, not only for FY'09 but we are looking out to FY'10 and FY'11, saying each year that we know we are going to face cuts. States are also looking at the same battles with infrastructure, with the way states are set up, and their inability in many ways to retool.

Unfortunately, it is in response to a crisis, so retooling as a kind of a knee-jerk reaction sometimes is not the way to go. However, we are battling federal silos. We all know what those silos are at the federal level that dictate what we have to do at the state level.

I think we have a paradigm that we need to change, that mental health is the responsibility of the state. That translates into the state mental health authority, which translates into my primary population being those with serious emotional disorders (SED) and serious mental illness (SMI) and is much more of a forensic population. That model leads to the exclusion

I think we have a paradigm that we need to change, that mental health is the responsibility of the state.

of prevention and early intervention. I have limited power and authority to set policy or to tell any other child-serving agency how to spend their money or what their policies ought to be. Prevention and early intervention are not in the mix for many states that have charge of their money; they have chosen to silo funding to work only with the sickest of the sick children. Not a bad thing, but you cannot get upstream in that structure.

Sue L. Smith, Ed.D.

Executive Director, Georgia Parent Support Network

“Let us, then, be up and doing,
With a heart for any fate;
Still achieving, still pursuing,
Learn to labor and to wait.”

That is from “A Psalm of Life” by [Henry Wadsworth] Longfellow. My mother used to read it to me every day to wake me up. She died when I was 17, so it is on the back of my business card. And you know, I think he might have gotten it wrong, maybe the time to wait is over. Collectively in this room, there is enough power and knowledge to get the work done that has to be done.

It has been an incredibly interesting road for these years. It is like we are at the stage of either getting it done right now or beginning to

Conclusion

As we are currently constructed in states, we cannot get there from here without a radical, fundamental change in how we think about the responsibility of mental health, mental illnesses, and wellness for children. The state mental health authority is only a small, significant but small, piece in a very, very large pie. If indeed we believe that mental health is the linchpin to overall health, we have to rethink how we are structured.

This country has to make a true commitment and put our money where our mouth is. No one would say that we do not care about children. But our policies and our dollars do not support that sentimental thought. They just don’t. As Ms. Edelman said, it is not just child mental health. What are we doing about prenatal care? What are we doing about subsidized, good daycare? What are we doing about schools, whose broader view around test scores causes them to get kids kicked out and not be able to be part of that positive moving forward?

Now it is time to seize our opportunity, with new life, new blood in Washington. So you have a heavy charge, a critical charge, to give us that new paradigm to move forward.

pass the torch to those to come, and that is a really important place to be. I honor the research, certainly all of the work that has gone into the best practices and everything else that has gone into the work but, for me, it is about the heart.

About 23 years ago, I received a call from a person in Georgia who said they had a “throwaway kid.” I was a parent and had never heard any of the things that I am hearing now. “What do you mean, throwaway kid?” I said. And he said, “It is a child in this state not deemed worthy of spending any money on because these children are not going to make it anyway. I want you to come out here and I want you to raise hell with them, and get him services.”



I met Jane Knitzer when I was first advocating for my daughter, who is now 32 years old. She was one of the children who was not going to make it. One of the things Jane said to me that day was you have to stand up and fight. If you do not fight, she is not going to make it. Shortly after that she was hospitalized in one of the Georgia hospitals. Nine Emory [University] doctors stood around her bed

Collectively, a lot of us did that, and he did get services. From the cradle to the prisons: I think it is just a new way of saying what is happening to our kids. We are not willing to put the money or the resources in, so, literally, if we do not do something about it, we are perpetuating the throwaway children.

The good news is we know what to do. This is not 25 years ago. We have spent those years figuring out what to do and how to do it better. This knowledge will continue to evolve, so let's do it.

We have heard the statistics from the states, and I was honored to be a small part of the group that met and talked about it before it was published, wondering, "Well, how do we measure? How do we really know what some of our imperfect measuring systems are measuring and if those measures are accurate?" And that was one of the things that really bothered me. This is, in my opinion, incredible work. We need incredible systems to measure our work so we know how good it is.

and said you need to leave her in the hospital. You need to go away and never come back because she is only going to be a heartbreak to you.

We did not go away, and today she has a college degree. She has lived away from home in a dorm. She drives her own car, makes her own living, and owns her own home. Would that have happened if we had walked away?

I heard both Jane and Marian say we can do it better than that. Of course we can. We all know that. I heard our charge: Build a consensus to shape a new generation of children's mental health system, and that is what we have to do. And, I believe, yes, we can.

We are not willing to put the money or the resources in, so, literally, if we do not do something about it, we are perpetuating the throwaway children.

Discussion

P. Jensen: I am a child and adolescent psychiatrist and the president and CEO of the REACH Institute. I think there are two things that are key problems. I also think there are some solutions that are real, practical, and achievable.

First is the issue of quality. We know that there is an 18- to 20-year gap between what we know and what we do. Based on what we know about the latest science, if we ensured that every child got that kind of care now, we would drop from 14 million children with mental health problems across the country to maybe 10 million. Our treatments are not perfect; we will not get rid of it totally, but that's 4 million children's lives saved.

The other problem has to do with access. I have colleagues in my discipline who are practicing in New York City and who charge \$1,000 an hour. When I sit on panels at my organization, the question that comes to us is, "Well, do you take Medicaid or managed care?" I have been in academia so that question has not applied to me. But all my colleagues say, "No, I do not take managed care, and I feel really guilty about it." Now the interesting thing is they do feel guilty about it. They feel sad because they went into this discipline because they wanted to make a difference for children. So how did they end up in this spot?

We are the last stop. If you gave every kid—the 14 million children in America—to a child and adolescent psychiatrist and said, "Guys and gals, divvy up your time." Guess what? We would have one and a half hours a year to spend with every child. We are never going to get there the way we are organized, not in our lifetimes. Reorganization of our health care services, drawing upon primary care and our colleagues, and understanding how we use child psychiatry and psychology and social work are absolutely essential, as is training in evidence-based practices.

P. Fink: I want to call everybody's attention to the big issue of trauma, violence, and abuse. This is the bad, empty side of the glass, so to speak. Einar Helander, who worked for the World Health Organization for 30 years, has written a new book titled, "Children and Violence: The World of the Defenseless." It outlines the pain and destruction we bring to children. We have to find a way to deal with that.

J. Knitzer: We did ask the states about their efforts on trauma. We have separate things going on with trauma and they are not infused into the mental health system, at our peril. The

states do report and some are screening in juvenile justice. But we need much more attention to trauma, and we need much more attention to our family focus because the parents of many of these kids have been traumatized and their trauma has not been treated.

P. Leaf: If we are talking about developing a public mental health system or a public health approach, I think we need to also look at where the children and youth are, which means our preschool programs, our child care programs,



Jane Knitzer

Discussion

our schools, and, increasingly, out-of-school programs, which includes lots of NGOs and faith-based programs. Not many of our mental health experts are really working in these systems, although there are many mental health people in these systems who I think could benefit enormously from collaborating with us, as well as we could benefit enormously from collaborating with them.

J. Knitzer: One bit of reality. We still have some states that only pay for office-based care and do not pay for reimbursement in the settings that you are talking about. This is a huge issue, putting our money where our mouths are.

C. Bell: I agree with the issue of states being responsible for the seriously mentally ill and that they are not even in the prevention conversation. In Illinois, our former first lady, Lura Lynn Ryan, had this synergy, but when she left office, it stopped. We learned that most of the money going to prevention is not coming for mental health. When there is such an effort, how do you institutionalize it and continue it as people change office?

There are a lot of people, anti-psychiatrists, who are suing people for screening children for early disorders. And they are attacking all of the prevention and public health interventions that

we are trying to push forward. They are very slick, very good, and very voracious. How do we institutionalize the synergy Dr. Henry talked about and how do we deal with these anti-psychiatrists who are attacking our efforts to put prevention and public health in place?

R. Henry: When you get something institutionalized, it is because you have to do it. When things are voluntary, often times it does not get done. Example: The block grant for substance abuse has a 20 percent set-aside that has to be spent on prevention. No matter if I'm a state substance abuse director today and Sue is the substance abuse director from four years ago, and four years coming there is Patrick, he has to pay attention to prevention because it is part of the law and a requirement for the funds we receive. It is a way of saying we are going to put our money where our mouth is on prevention support. That is one way you can begin to institutionalize it.

J. Knitzer: I just want to comment on institutionalization in policy. The devil is in the details of policy and that is what we need to take a hard look at. Looking at the prevention block grant is one of them but we have lots of policy recommendations in there and we would like help in thinking about how good they are, and how much traction they have.

PANEL I: FAMILY, YOUTH, AND COMMUNITY PERSPECTIVES

Janice L. Cooper, Ph.D., M.P.A.

Director, Child Health and Mental Health, National Center for Children in Poverty, Mailman School of Public Health, Columbia University

When we embarked on this journey about how to craft something that would do justice to the study that Jane Knitzer had done in 1982, we convened a group of family members, youth advocates, and community leaders to talk about what they would want to see out of a new report. One of the things they told us was we want to see a DVD produced of parents talking to other parents, youth talking to other youth, and also reflecting the fact that, right now, we have generations of families that have been in the children's mental health system who are now watching their grandchildren go through the children's mental health system. So we produced a DVD to give you a little bit of the family voice. (View the DVD at http://nccp.org/projects/events/video_13.html.)

I am going to talk about the part of our report that has to do with questions we asked around family and youth engagement and the role of families and policy. We wanted to know from states how well they responded to the needs of family and youth who accessed services. So we asked states to:

- describe their efforts to strengthen the family and youth voice and policy;
- tell us about funding for family and youth organizations;
- tell us about whether they were funding family treatment and parental depression; and,
- state whether funding for family support was paid for by Medicaid or through state funding.

Thirty-nine states reported on a range of efforts to inject and sustain the family and youth voice and policy. But 79 percent of the state mental health advocates to whom we asked the same question told us that they were terribly

dissatisfied with the role of family and youth voice in child mental health policy. So there is some disconnect there.

We asked states to tell us about the strategies they used to foster family and youth empowerment. They pointed to a number of strategies:

- family and youth in regulatory and legislative bodies;
- state mental health decision making where they are involved;
- support for organized parent network and advocacy; and
- service delivery and leadership (Did they foster family participation through their funding, support, and/or training? Were they providing other types of support for family leadership?).

Problems Reported

We asked the advocates what they saw as some of the problems, and they told us they were dissatisfied with the depth of the family voice in policy. And we asked them to tell us about things that most concerned them. They listed the following:

- Inconsistency in the state's approach to including the family and youth voice. They noted that, if there was a funding cut, the first thing to go would be family advocacy.
- Poor commitment to families. One example: the mental health director might have made a commitment but did not have the power or the authority to do so.
- Concern about neglecting the youth voice even though, in comparison to the family movement, the youth voice seems to be coming up fast.
- Inadequate tools provided to families to engage and sustain families and policy and the need for continuous education.

- Lack of leadership on the part of states to be more serious in terms of sustaining the family voice.

Another question asked, “Tell us about the advocacy groups you supported.” Support for these advocacy organizations was evidenced in different ways. Some do pure advocacy, some do education, some do more family support. So there is a range of services and strategies that these organizations provide.

Funding for Family Treatment

We asked states to tell us about funding in their state budget for family treatment and parental depression. In other words, was there an experience modification rating in your state budget? Again, we tried as much as possible to take a developmental approach, so we asked the states for all the age groups:

- Nineteen states reported funding for family treatment for family members of young children.
- Eight states reported funding for parental depression for family members of young children.
- Twenty states reported funding for family treatment related to the care of school-aged children and youth.
- Eleven states reported funding for parental depression for family members of school-aged children.

Funding for Family Support

Twenty-five states reported that they funded family support. Eight states reported that they funded it under certain circumstances, and five states reported that they did not fund family support at all.

Funding for family members and youth in professional roles probably excites me the most. Nineteen states still do not permit Medicaid reimbursement for family members in professional roles; 28 states use state dollars for family members in professional roles; 12 permit

reimbursement for youth in professional roles; and 24 states permit using state dollars for youth in professional roles.

What type of professional roles are we talking about? Family members serve as trainers, many of them as wraparound trainers, as wraparound facilitators, staff, case managers, and in other administrative roles, and similarly for youth. So, given the fact that the youth movement is fairly new, it seems encouraging.

Policy Challenges

Asking the states about policy challenges was not a question specific to families and youth. This was a question about the next five years: What are the policy challenges that you think you will face? It was interesting for us that states noted family and youth engagement emerging as a top policy challenge and an opportunity for reform.

Recommendations

We have some recommendations in the back of the report in the family section that really talk about how, from both a federal and a state perspective, we might be able to support and sustain the family and youth voice. Those recommendations are as follows:

- Provide incentives to ensure that states solidify and sustain the family and youth voices and policy. The myriad of barriers in Medicaid to really engaging families and supporting family treatment was very clear from our work.
- Develop guidelines for the state because sometimes states do not use Medicaid—they think they are not allowed to. Also, there is a need for the Center for Medicare and Medicaid Services to provide some guidance about how you might use Medicaid to support a family and youth responsive system of care.

(Read the report at http://www.nccp.org/publications/pub_853.html.)

States noted family and youth engagement emerging as a top policy challenge and an opportunity for reform.

RESPONDENTS

Moderator, *Sandra Spencer*

Executive Director, Federation of Families for Children's Mental Health

A youth organization called Youth M.O.V.E. National, which is a subsidiary of the National Federation of Families for Children's Mental Health, is up and coming. Its members have been through multiple systems, and they are so resilient. They are now speaking and talking all over the country about youth issues, having a voice and changing systems. Having been a part of the family movement, I think this youth movement is moving pretty quickly; but, I guess it is all relative because those young people are still saying no one is listening to us, our voice is not heard. We are rallying behind them to help them get to a place where they do feel listened to and validated and where they can push forth change.

The first Unclaimed Children report launched the family movement, and it launched the Federation of Families for Children's Mental Health to give voice to parents and other caregivers who were raising children with mental health issues and who just could not get the services and support they needed, couldn't have a voice, and, it seemed, couldn't move policies and procedures forward. We have seen where a

lot of states are supporting families and family-run organizations, and we need to figure out how to put forth the same kind of support and resources so that families can do policy and advocacy work because it is critical. Families are voicing their disappointment in not being able to

come up with the resources to sustain their policy voice, and I think that is a huge, missing, and critical piece.

The young people are really pulling themselves together, and they have a voice. They have things that they want to do, things that they want to change about our system and how systems are run. And yet they are already up against the wall of not having the resources and the supports to be able to do those kinds of things. We need to make sure that we are providing those tools to our families and to our young people.

One of the things that I am really proud of is an upcoming event that is supported by the Center for Mental Health Services. We are getting ready to embark upon the first family-driven policy academy. And we are really serious about helping states create policies to push forward a family-driven agenda. This is an area where Georgetown University excels. They have been very successful in these policy academies and in helping states change policies. As a national family organization, though, we were afraid that we would not get any buy-in from states. However, 11 states have applied already for the family-driven policy academy.

We realize that states are serious about pushing the envelope, about hearing family voices, and about having family members heard who are raising children with mental health issues. Our goal is to change states' policies and procedures so that families can be on governing boards, be a part of committees, and have decision-making roles in their states so that we can really begin to seriously change the system and have a great impact. We know that in any field you have to have the end users. Who is using our system? Whose voices should we be listening to?

There are a lot of things that families want to confront, such as issues of cultural and linguistic competencies, and the disproportionate number of children of color who are in our systems. We want to tackle a lot of things.



Janice L. Charles

Executive Director, North Country Children's Clinic, New York

I am not a mental health professional. I am a public health nurse, and North Country Children's Clinic is a public health model. What that means to us is that we provide preventive services, education, diagnosis and treatment, support services, referral services, and medical, mental health, dental, and the Women, Infants and Children (WIC) program. Our clinical psychologist, Dr. Jean Emory, wrote an article about the mental health program model that we have put into place, which is an integrated model of care with our primary medical program combined with our mental health professionals. The article, published in the National Health Association's magazine *Rural Roads* in December 2007 describes at length how that service works.

We have a professional team working together that includes our pediatricians, nurse practitioners, registered nurses—all in the medical program. It also includes our licensed clinical social workers and clinical psychologist. We practice in our community center, as well as in our school-based health centers, where indeed we involve a lot of the youth and, sometimes, the parents if they get involved at any level with the care. It is a different approach, not your typical model or mental health model, and the children's clinic has always been outside the box from day one, about 30 years

ago. We try to do whatever we can to work with families. We focus on serving uninsured children in poverty, not an easy job when you are talking medical care or mental health.

I did not see mention of the shortage of mental health providers in your report. We see this very acutely in our rural areas in New York state. About two years ago, I was on a task force that was studying this issue and trying to determine something we might be able to do about it because one of those categories of professionals is a certified child psychiatrist. Two years ago, there were about 7,000 of those providers in our country. I do not know if that number has gone up but an area that we seriously researched was telemedicine and telepsychiatry. You can connect a child in Watertown, N.Y., with a child psychiatrist in the Neuropsychology Center of Columbia University in New York City.



A lot can be accomplished using telemedicine when you do not have those providers in your community. Right now, we are without the certified child psychiatrist. That makes a big difference to the treatment team and how well children can do. When we lack providers, the information technology side and electronic systems are incredibly important.

Electronic networks are also a very important piece of that. We have received grant funding in the North Country through the Fort Drum Regional Health Planning Organization, which is there to provide and plan for services for the military because Fort Drum, the home of the

10th Mountain Division, is 10 miles from us. The soldiers there, both men and women, are deployed many, many times to Iraq and Afghanistan, so we have been working with children from those families. The fort itself does not provide mental health services for the family members, so it has fallen back on the community.

We want access for mental health care and other health care services. We have to have it. When you have uninsured children like we do in our clinic, you have to have funding to take care of them. And, these days, it is very, very hard to come by. Universal health insurance has to be the way we go.

Captain Verrottica Young

Advocate Youth Training Project/California Youth Connection

I sit on one of the advisory boards for Unclaimed Children Revisited, the Research Group, and I think linguistic diversity is huge. Basically, it is talking so that people can understand, putting things in documents so that everyone is able to read and understand, from young people, maybe even children, all the way up to people who are professionals with degrees. Using different methods, reaching different communities, and different types of people is huge.

As far as mental health is concerned, we have to keep in mind that we are not focusing

We have to keep in mind that we are not focusing on what affects mental health but what mental health affects.

on what affects mental health but what mental health affects. And I say that because there is a wide definition of mental health. I view mental health from the point of view of a youth who has been through the system, who has been to juvenile hall, been in foster care, and in kinship care. I have two parents who are incarcerated, and siblings who have followed in my footsteps and in my parents' footsteps.

One of my sisters was 16 when she had her baby. So, automatically, she was placed in a mandate for court, she has a Child Protective Services (CPS) case on file. And these things

lead to diagnosis of the children. There are mental health factors that are affected by community. Not having food, that is a mental health issue because if you do not have anything to eat, you are not going to be worried about how well you are doing in school.

As young people move through the pipeline—by definition, I am still in the pipeline because you have seven years after you are 18 to re-enter the system, and I have not passed that time yet—the trauma continues when they enter juvenile justice and correction facilities, or if you have never entered these facilities and you come from certain communities where kinship parents do not receive funding for taking care of you. Then, there are the violent offenders who are not necessarily getting treated for mental health issues but are just getting treated for being in the wrong, having felonies, or having a violent past.

I work in many different avenues of advocacy and work with racial disparity groups around youth engagement, working with California's Connection, and in Hawaii with the National Foster Youth Program.

Some of the issues that I want to see tackled include how we are going to begin to address things like prostitution and automatic diagnosis of LGBTQ [lesbian, gay, bisexual, transgender, questioning] youth. A huge part of my advocacy background is across the different systems. How

do we get the systems integrated and interwoven? Because young people may leave foster care and go to juvenile justice, their case may have been closed in foster care. Then, they re-enter foster care and a new case has to be opened. Services may have been disconnected or different services or labels may be added that may or may not apply.

Involving young people at a fair rate of pay, inviting them on your boards, inviting them to speak, providing adequate services and care to them—sometimes young people will show up just to do a speaking engagement and you do not know what they are going back to. They may not be going back to anything. I cannot say the cup is half full or the cup is half empty. All I know is, I just had water in my cup, I just had water in my life. You have to meet young people where they are, and be true to them. Let them give back what they can. A lot of us go back to nothing, and a lot of us go back to violence, to homelessness. How do we fill our well of wellness? How do we bond with different detachments? And, how do we move through life without getting in trouble but also feeling good, being seen, and feeling beautiful?

Youth Training Project

I am a youth trainer. I have been training with the Youth Training Project for about four or five years. It is a group of current and former foster youth from ages 14 to 24. We are working on developing policy and legislation with the

policymakers so that all the policies have been developed with young people who have trained other young people. Okay, here is a small idea: What is affecting me? How can I go back and say this is what the policy needs to include or this is what does not need to be included in other people's policies, because we look at other people's policies as well.

The Youth Training Project trains social work supervisors, social workers, judges, lawyers—anybody who will pay—about the different issues around positive youth development. We talk about detachment theory, well to wellness. We talk about mental health needs. We share our personal experiences in a healthy manner because, a lot of times, when people share their personal experiences they relive the trauma. We do not want to be exploiting young people, we want to empower them. That is what it's all about, giving them the same benefits, having them on the same level, being able to sit in rooms where you do not necessarily see a lot of people who are like you or act like you and that means a lot to young people.

There is a movement to get the next generation of young people to become leaders. If you are a former foster youth, or if you have received mental health services, it is important to communicate that to young people who are currently in foster care or receiving mental health services or in juvenile justice. We need to see leaders who are receiving and will still be receiving mental health services even during their professional lives.

Dalia S. Smith

Family Advocate, Association for Children's Mental Health, Michigan

I wanted to start out by giving a little biography. I was born in 1976 and raised by my paternal grandparents, who also raised my half brother and sister who were not related to them. They provided stability for us all the way through high school.

A lot of mental health issues on my paternal side had not been addressed for my aunts, uncles, and cousins. I inherited some of those issues. Because of the stigma mental health issues had in

the middle 1980s, when I was starting to have problems, they went untreated. My family had experienced stigma in their past with other relatives who went into institutions. So I did not get mental health treatment for my diagnosis or for the trauma that I had experienced as a little tot. And it created problems. I like to say sometimes that, with my grandparents, I had a 1950s upbringing with some 1990s rebellion added. What got me through my childhood into

the early adult years was the resilience that my grandparents instilled through those 1950s values.

I was able to go on to college and get a degree from the University of Michigan. I lived in Scotland and traveled all over Europe. In 2000, I married and became pregnant. That is when the untreated illness lambasted me. It was a really awful experience, really debilitating. Throughout my pregnancy, which I had looked forward to being a really pleasant time, I was caught on the fringe of the Michigan mental health system. Luckily, in the very beginning I was able to get into a program for maternal depression.

And then, as so often happens with people with a mental health diagnosis, you feel better and get out of treatment. So I was feeling better and did not go to treatment anymore. A couple of months later, I was going in and out of the local hospital, including a suicide attempt while



I was pregnant. That was the point when I knew that I could not turn my back on treatment. I had to stay in treatment. I had to get better for my son's sake and for myself. I had to raise this child.

At the same time, there was domestic violence in my marriage, and I had to gather strength from all the different corners and leave. My son was 18 months old when we moved to Saginaw County in Michigan and I pretty much started over. I was able to get into the Saginaw County mental health system immediately. I knew I had to have continuous treatment, although at the time I did not understand the disconnect from county to county. I was able to get into the infant mental health program.

Originally, I had gone through the adult intake but, because of talking about my infant son and the trauma that he experienced through the domestic violence, they were able to divert me into the infant mental health programs. That was the saving grace, and I did not even realize it. Through that I was able to get the mental health services for our family, for my son, and for myself.

I faced homelessness and transportation barriers, and I had a child who, at 18 months, was having behavioral issues, which created a struggle to find suitable daycare that would keep him. My family did not want to watch him while I went on a job search, or went to school, or grocery shopping. It was a hard time.

At the same time, I was also dealing with a custody battle with my ex-husband. That was an awful experience because everything about the mental health part in our relationship, about me going in the hospital and the suicide attempt, came back to slap me in the face. My lawyer had told me, because of all the things that I was working against, that it would be an uphill battle, that it did not look good. But in the end, I did prevail, and I think that was because of the commitment I had to the mental health services that I was receiving.

Ms. Edelman talked about kids facing expulsion in preschool. Well, that's my son, who was not identified as a special education student at that time. He broke the school policy about assault, was expelled for the last part of the school year, and was not able to participate in his picnic. He

did not understand at the time, but it started a challenging journey through the special education system.

Advocacy

I became involved in the Saginaw Human Services Collaborative Body and that planted the seed for my advocacy work. I was a parent representative on the board and from that became a part of committees in the community. Eventually I was able to become a family advocate for the Association for Children's Mental Health.

Although I struggle with capacity, this is my fourth year doing advocacy work in Saginaw County. I am still struggling with the buy-in from the service providers on the ground level of service delivery and with convincing service providers that they are answering to the parents and not the other way around.

Through my advocacy work, I see that parents are hungry for information about mental health and are hungry for empowerment. My child, Jacob, is not going to experience a fixed system in his childhood. But what I can do as a parent is instill the value of mental health and nurture in him the belief in human goodness and hope. My hope is to help other parents do the same for their kids.

Challenges

We face stigma with a diagnosis and substance abuse issues. You know, substance abuse is almost more stigmatizing than having a mental health diagnosis. I still see parents who are pregnant and not able to get into the services that they need, or who cannot get diagnosed when they are pregnant.

The graduation rate of special education students, especially those with emotional impairments, is

just horrendous.

Look at the statistics: 2

percent graduate.

Michigan also has

new graduation

requirements. In

order to get a

diploma, you have

to have four years of math, science, English,

social studies, and history. Kids who have a

combined learning disability and mental health

disorder, or whose mental health disorder is really

impacting their education are not going to be

able to get a diploma. So we have to really work

on how they are going to get the same standard

of education as the regular students and still get

a diploma.

Saginaw is doing some really encouraging things. One is they are getting a mobile crisis unit. After hours and on the weekends, when parents need to call and they do not know what to do, the mobile crisis team can go out and help them address some of their concerns with their kids.

Our community is also addressing post-traumatic stress disorder (PTSD). My son and I have PTSD as a result of what we have experienced. I can tell you that one of the most effective treatments that I have had was doing trauma therapy work, the trauma narrative and all that. Through therapy, I am now able to be more in control, because I do not have the influence of the trauma stuff coming up. We are becoming a trauma-informed community, and I think that is awesome.

I am still struggling with the buy-in from the service providers on the ground level of service delivery and with convincing service providers that they are answering to the parents and not the other way around.

Carmen Diaz

Chief Parent Advocate, Los Angeles County Department of Mental Health; Board President, United Advocates for Children and Families

I came to this position because of my children. I raised six children, four of my own and two of my sister's. My youngest child was diagnosed with severe attention-deficit/hyperactivity disorder. And, with the help of my friends, my neighbors, and the community I lived in, he graduated from high school. On the day he graduated, he told me, "Mother, I graduated for you but don't expect me to go to college. I'm not going to sit in a room and learn when you know I can't sit still." Well, he's a thriving person. He installs kitchen countertops, which is perfect for him because he is not sitting in an office or in a warehouse. He is out and about. I also raised a niece who went from traditional therapy to a locked facility where she still resides.

People kept asking me why I got into a parent

Many times, parents feel they have to relinquish the rights to their children because they do not get the services they need.

advocacy role. The only thing I could think of that was an honest response was revenge. Not a mean revenge, it is just a little bit of trying to get back, trying to

help other parents not go through what I went through. The system was not going to do to them what it did to me.

And I was a pretty lucky person in the system. When my son was 2 or 3 years old, I knew there was something wrong with him. I went to a medical doctor and said, "Dr. Dan, something's wrong with him." He said, "Oh no, he's just a little different, a little hyper." I heard that until my son was in second grade.

Toward the end of that school year, his teacher called me to the office and said, "I just cannot do it anymore. I just can't teach your son. He does not sit still long enough to learn anything." Then, she kind of stepped away. I guess she figured I would be upset because of what she told me, but I wasn't. I wanted to kiss her because I had seen this since my son was 2 or 3 years old but no one else had seen it. She asked me if I would mind if he went through an evaluation, and that is when I started learning how to go through the mental health process.

What I found is there may be services out there, but there are not very many for parents who are looking for services for their children. So what happens is, many times, parents feel they have to relinquish the rights to their children because they do not get the services they need. People will tell them if they were involved with Children Services, they would get the services they need. Now, I know that all departments have their problems sometimes getting services. I know this now because I work with them.

Los Angeles County hired five of us for children's system of care. We asked, what are we supposed to do as parent advocates? They said advocate for the families, advocate for parents. So that is exactly what we did. When my boss said we needed someone to go to the Senate hearings in Sacramento, I said, "Not me, get one of the other parents." Well look at me now.

I was lucky to experience sitting on the Oversight and Accountability Commission for Mental Health Services Act. I termed out, but I learned a lot and discovered what parents need to learn before they start sitting on policy-making boards is the language. We do not know the language. Acronyms are murder. When I first started, I would sit in a meeting and keep quiet; I would not say anything. I did not understand half the things being said. Now, I get a little brave. Now I stop and say, "What do you mean? What are you talking about?" I found that a lot of professionals do not understand what they are talking about either. In one of my experiences, they were using acronyms in a meeting. I said, "Excuse me, what does that stand for?" The social worker sitting next to me said, "Thank you for asking. I didn't want to ask because I didn't want to sound stupid."

Parents, caregivers, and I think it is true for youth too, need to learn how and when to speak and how to speak, not what to say but how to say it. When we are asking for services for our children, we learn to yell, scream, cuss, and bang on tables because no one listens to us. Sometimes, this is how we get services. We also



get the title of crazy parents. It is not that we are crazy; it is that we are looking for services for our children who need them.

Give your parents the education they need. Give them a list of acronyms and terms and what they mean, and you will get a lot more information from parents. It is not the parents' fault. It is time to stop pointing fingers and saying, oh my goodness, look what her mother did to her. Parents know their children better than anybody, so we need to start working with parents.

Training is the only thing that is going to get to some. A lot of times it is the mindset. You have a lot of professionals that do trainings for

wraparound in children's systems of care, and you would not believe the things they come up with sometimes because of their mindset. So we need to hit universities and colleges and high schools and start training them, educating them on how to interact with families, how to talk to families, and how to include families in everything. We cannot just assume people are going to know how to do that because it is a learning issue. And, at the same time, you teach families how to work with professionals. Basically, I think we are all going in the right direction. I just think it is going to take longer than we think.

SPECIAL TRIBUTE: REMEMBERING JULIUS RICHMOND

September 26, 1916 – July 27, 2008

Rosalynn Carter

Chair, Carter Center Mental Health Task Force

I am privileged to pay tribute to Dr. Julius Richmond. Julie served as surgeon general when Jimmy was president, and I got to know him then. He has meant so much to me over all of these years. Julie used to say that he was a “pediatrician gone astray,” and I think we all are very glad that he went astray deep into mental health.

He was a remarkable man and touched the lives of all American children and their families whether they knew it or not. He was often referred to as “the grandfather of Head Start.” And I worked with him on the first-ever national immunization campaign for children when Jimmy was president. When we first arrived in Washington, D.C., I found that only 15 states in this country required immunizations by school age. That is hard to believe now. But we were able to mandate immunizations as part of school registration in all 50 states, thinking we had preventable childhood diseases under control.

Julie also helped me organize a program called Every Child by Two that promotes age-appropriate immunizations and encourages registering 2-year-olds for school because then they must get their shots. I am still working on this with former first lady of Arkansas Betty Bumpers. In Georgia, I was able to get voluntary legislation passed permitting school registration at age 2. I was hoping that it would be like car safety seats for babies: It started as a voluntary program but when people began talking about it, it soon became the law. With the help of the Department of Family and

Children Services, one Georgia county agreed to participate. Of the first 1,200 children who were immunized, 21 percent of them were identified as having a medical problem or a developmental disability. A lot of these families had never gone to a clinic before.

Julius established the national Healthy People goals, which continue to this day. He was involved in the beginning of community health centers, which evolved into our current system of federally qualified health centers, the backbone of our public health system. But I really got to know him well working on mental health issues. When we left the White House, Julie agreed to participate on our Mental Health Task Force and remained active until he passed away earlier this year.

He also was on the board of the Rosalynn Carter Institute for Caregiving, which grew out of my mental health work. My local state university had a small endowment to establish a mental health program, but by the time I began to work with them, I already had a good program here at The Carter Center, so we decided to work with those caring for loved ones with mental illnesses. However, it quickly spread to caregivers for all types of illnesses.

Julius touched literally millions of Americans’ lives through his work. And that does not even include the millions he impacted internationally. It is fitting to honor his life, particularly at this symposium. He would have been so glad to see us do whatever we can to further the findings of Unclaimed Children Revisited.

David Satcher, M.D.

Director, Satcher Health Leadership Institute at Morehouse School of Medicine; John D. MacArthur Professor of Health Policy, Emeritus, Harvard University; Member, Carter Center Mental Health Task Force

Julius Richmond was an unusual man. We were the only two people to serve as both surgeon general and assistant secretary of health at the same time, and he really set the bar very high for that position. Actually, he never gave it up. Periodically, Julius would call me and say, “David, how are you doing?” At first I thought

he was concerned about my health. But what he really meant was, How are you doing in your job? How are you doing in carrying out the mission that we care so much about? We shared a passion for children and for the health of children, for poor children. I grew up in that kind of environment, and I always appreciated Julius’

leadership. I understand that more than 25 million children have now gone through the Head Start program. Some of them are now in their 40s—he is often referred to as the grandfather of Head Start—so it is a tremendous contribution that he made.

In the September issue of the CityMatCH newsletter, City Lights, Magda Peck wrote an article about Julius called the “Invisible Hero,” and talked about the fact that he was so unassuming he was not one who cared about getting credit. She tells this story:

At a conference, a lady came up to Dr. Richmond after he spoke and said, “Why don’t you get angrier when other people take responsibility for your work, like starting Head Start?” Julius looked at her and said, “Well, you know, the Head Start program is in the public domain and the more people who take credit for it the better. That’s more support.”

That was so Julius Richmond.

He cared deeply and I think it was, in great part, his caring that kept him going all of those years. In our leadership program, we say that we need the kind of leaders who care enough, know enough, are courageous enough to do enough, and who are persistent in the struggle. How much we care is important. We have a

In our leadership program, we say that we need the kind of leaders who care enough, know enough, are courageous enough to do enough, and who are persistent in the struggle.

saying in medicine: People really do not care how much you know until they

know how much you care. That is certainly true a lot of times in dealing with patients from different backgrounds. Julius cared deeply about the health of children, about mental health. He was really special in that regard.

In the Gettysburg Address, Lincoln, after reflecting on the tremendous contribution of those who had died in that tremendous battle, made the statement, and I paraphrase: In the final analysis, it is not about them, it is about us. They have given their last full measure of devotion. But the question is, will we continue the work that they started? I certainly think that is true when we think about Julius. I think he would have liked for us to really say now it is time for us to make sure that we continue to work so that every child, as Marian Wright

Edelman said, has access to a quality life experience, to a head start and a healthy start in life, where we continue to work for mental health. And, to see that mental health parity is implemented all over this country, which means that we have to make some changes.

Julius was such a fighter. He is the one who testified on behalf of the flight attendants’ issue of secondhand smoke exposure. They won their suit, in great part, because of his testimony. The question facing us is, will we continue to work to see that Congress gives the FDA the authority to regulate tobacco as a drug? These are the things that he really cared about. I think the greatest way that we could honor him would be to continue the struggle—it is a struggle, and I know we get tired sometimes struggling for things that should have happened a long time ago. But we must continue. Julius did until his death.

I was invited to do a two-day visiting professorship at Harvard in April on public health leadership and decided not to call Julius because I had heard he was very ill and was taking chemotherapy. About two weeks before I was to go, I got this call from Julius. “David, I understand you’re going to be here in a few weeks.” I said, “Yeah, I’ll be there.” Julius said, “Well, we have to get together.” I was able to spend about two hours with him. He attended the university lecture that I gave and that is how I want to remember Julius, the time that I was able to spend with him then. One of my favorite poems is by Longfellow; somebody mentioned it this morning. It is from “A Psalm of Life.” But the part that I have always liked to quote is about footprints:

“Lives of great men all remind us
We can make our lives sublime,
And, departing, leave behind us
Footprints on the sands of time;

Footprints, that perhaps another,
Sailing o’er life’s solemn main,
A forlorn and shipwrecked brother,
Seeing, shall take heart again.

Let us, then, be up and doing,
With a heart for any fate;
Still achieving, still pursuing,
Learn to labor and to wait.”

DINNER COMMENTS

Jeannie Ritter

First Lady of Colorado

Mental health is not my background, my area of expertise. I actually have a profession in teaching small people to sound out words. I really love my background in education. But when my husband was elected governor of Colorado, I saw this opportunity to work on behalf of an important issue that does not get the attention it deserves.

I connected community mental health services to veterans in their communities. In Colorado, we have a lot of National Guardsmen and reservists. They do not go back to the military base, they go back to their communities. They are dental hygienists and middle school teachers. As they come up against their issues, I wanted to connect them quickly to their community resources. It has been very rewarding.

The community mental health centers in Colorado welcomed me with open arms, and I went all around the state of Colorado. We have very distinct communities: Front Range, mountain resort, ranches, eastern plains, and we have two Native American reservations. We have huge diversity. I was fortunate enough to bump up against great leadership in behavioral health, and I got to see what takes place at the ground level and how leadership creates programs that really meet the needs specific to communities.

I have not let anybody off the hook regarding mental health. I am out speaking with seniors and judicial veterans and those in early childhood, law enforcement, and corrections. The beauty of this issue is that it touches on everything. I will tell you what I lie awake about

at night: not delivery of services, not best practices. What I am worried about is building capacity. Some of us are graying, and we really have a responsibility to begin to pull in some people behind us.

Today, I started fantasizing. I have a very generous chair and I thought, could we just squeeze a small stool in next to that chair next year? Many of us would be happy to commit ourselves to mentoring. I know many of you have been advocates and providers, researchers, and funders. So I thought, what if I achieved the goal of reducing, or at least chipping away at the goal of reducing, stigma and increasing the level of awareness? People have no providers to go to, and I will have only created another problem.

I want to ask you to join me in seeking out who could be coming up behind us, who could shadow you now. Find the opportunities. Get in touch with some of the graduate schools, whether it is social work or some of the psychology programs at the universities near you. Just see who would be interested in coming out and sitting with you at some of the endless events that you go to or standing beside you in your work. Do not overlook the opportunity to mentor someone.

I cannot imagine very many groups who actually do all three of the things that The Carter Center does: You are waging peace when we talk about violence and trauma. You are fighting disease, and for sure you are building hope.

PANEL I I: UNCLAIMED CHILDREN REVISITED: IMPLICATIONS FOR IMPLEMENTING A PUBLIC HEALTH FRAMEWORK

Moderator, Rosa Gil, D.S.W.

President and CEO, Communitlife, Inc.; Member, Carter Center Mental Health Task Force

In the last 25 years, we have witnessed changes and advances in the knowledge, technology, and other aspects impacting children's mental health. However, data from the Children's Defense Fund on children, poverty, and other indicators, as well as the NCCP report, show that 88 percent of Latino children have unmet mental health needs, the highest in comparison to all ethnic and racial groups in the country. It suggests that we have our work cut out for us.

The foundations of mental health services for children and families in the 21st century need to be built on science that accurately represents the multicultural values of diverse populations. The face of America has changed dramatically in the last 25 years. For example, Hispanics have already become the largest ethnic and racial group in the United States. Mental health services for children and families are an integral element of a public health framework for the 21st century. This may not be easy to achieve because we continue to struggle with ethnocentricity.

I am very impressed by Dalia, Carmen, and Captain in their advocacy work. In addition to many advocates, we need different interventions to create a community-driven, 21st-century mental health system for children and families.

One of those interventions could evolve out of the experience of the recent presidential campaign. Many of us watched the former mayor of New York City, Rudy Giuliani, at the Republican National Convention where he asked the audience, "What is a community organizer and what does he do?" Take some lessons from it.

I have to say that it is not only Rudy who has to learn from the lessons of community organizations. I am a Cuban refugee. I came to this country in 1961, and I learned skills in community organization. There is a lesson for us in terms of moving an agenda for mental health. We need to knock on doors, make telephone calls to our neighbors, and use the Internet to involve neighborhoods and communities in the process of changing the mental health delivery system. We have Pablo Freire's educational paradigm that tells us how to intervene to move forward an agenda for a public health framework in the delivery of services for children and family in years to come. And, as I see it, there is no public health framework without community participation.

As I see it, there is no public health framework without community participation.

Sí, se puede! Yes, we can.

William R. Beardslee, M.D.

Psychiatrist-in-Chief, Children's Hospital, Harvard Medical School; Member, Carter Center Mental Health Task Force

This symposium has special meaning for me for two reasons. One is celebratory—I have admired the work of Jane Knitzer for many years, and I think the Unclaimed Children Revisited report is an incredibly important document that draws public attention to large but solvable problems. Second, as others, I mark the passing of Dr. Julius Richmond. I went to Children's Hospital in Boston in 1974 and worked with Dr. Richmond. That evolved into a

mentorship, friendship, and partnership that lasted up until a few weeks before his death last summer. He was a great mentor and friend to many of us, certainly to me and certainly to the Carter Center Mental Health Task Force.

It is particularly timely to think of him today because I have been asked to talk about young children, from conception to age 5, and their parents. Specifically, I have been asked to consider how to move forward the findings of

the Unclaimed Children Revisited report and the need for a public health perspective. Julius wrote a well-known paper titled, “Disadvantaged

In times of either natural disaster or economic downturn, it is those with the least resources who suffer the most and lose the most.

Children: What Have They Compelled Us to Learn?” I would like to take as my theme: “Unclaimed Children: What Have They Compelled Us to Learn?”

Friedrich Hölderlin said, “Where there is danger, there is also opportunity.” We live in very dangerous times for children. We have heard a lot about violence. We have heard a lot about children who are unclaimed, and we need to bear that in mind. I want to emphasize that that is particularly timely because in times of either natural disaster or economic downturn, it is those with the fewest resources who suffer the most and lose the most. As we face this massive economic downturn, I think we have to be particularly concerned about children ages 0 to 5, who are vulnerable and completely dependent, and their parents, and make special provisions for them.

But at the same time, we also have a great opportunity. If we use the Richmond model, we have a much greater, more powerful knowledge base than ever before. We have a number of examples of successful implementations of programs, and we have the opportunity to do much more. My remarks are influenced not only by the Unclaimed Children report, but I have been part of two Institute of Medicine committees. One is on prevention, which will review all of the prevention works since 1994 and be published in December 2008. The other one, chaired by Mary Jane England, M.D., and a fellow committee member, Jane Knitzer, was on parenting practice, depression, and the healthy development of children.

Drawing on these sources, I would say that there are three major principles in which they concur.

Physical health and mental health are inseparable. Promoting good physical health helps to cause good mental health and vice versa.

Prevention requires a paradigm shift, a long-term commitment to the shared futures of children. We should only be investing in programs that make a difference over the long term.

Whether it is 1981 when Unclaimed Children came out or 1994 with the prevention report, we simply have a much better knowledge base.

With young children, I would say that knowledge base really clusters into three areas. We know the value of high-quality, broad support early in life:

- high-quality day care
- high-quality nurse-home visitation
- integrative programs

We know about the value of economic support, housing support, and earned income tax credit. Why is evidence important? It is important because, when Hiro Yoshikawa reviewed that data, he found that the children only benefited from those kinds of programs if parents received a living wage. So it is not just the ideas but how we implement them. And, I think we know a good deal about reaching out to, or enriching, programs for those with special needs, special challenges in the area of depression.

There is wonderful work in the prevention of postpartum depression and very good work in drawing mothers and children into psychotherapy. We heard a very eloquent statement from Dalia Smith, who really is a supporter of and who benefited from infant mental health. But that was infant and mother mental health together.

With Julius’ support, we have been doing some work with Head Start. They estimate the rate of depression in early Head Start is about 50 percent. Our work has a common theme with other work across ages 0 to 3. We developed a teacher empowerment education program to deal with depression, rather than identifying depressed people and pulling them out to get therapy. Instead, it was much more to enrich the outreach, draw the parents into the usual activities of Head Start, and help the children through this. It is a public health approach, but it is driven by what I think characterizes the age group 0 to 5.

We ought to be thinking about this for all age groups. That is, we should be concerned about mental health insofar as it interferes with the appropriate developmental tasks of sitting still, learning to read, and so on. And we ought to put together programs that are focused on the accomplishment of those developmental tasks. Further, we need to put together coordinated, integrated systems that are not mazes that families have to battle through, but places where they can come to access all the services at one time.

Let me talk about health. There is a lot of interest in the concept of medical homes. I have argued that we need to put together medical homes and mental health homes so that there is one home, which needs to be family-centered rather than individual-centered. That is an example of what I think would be more parsimonious and have a much better chance of succeeding.

Often we hear about what we cannot do. We passed a law in Massachusetts to provide coverage for all, and we are doing it. This past summer, we passed a law to completely reframe and reform the child mental health system. What we found in the campaign for this child mental health system is that we had a huge number of partners that we did not expect to have. Sure, you can expect the professional organizations' support. But there were community organizations, dentists—all kinds of organizations signed on to support the legislation, because many people know the need for mental health services, and many people know they are not getting them.

We need to go further than that. We need to put together medical care with income supplementation, with high-quality daycare—powerful, integrative programs together—to break the two- and three-generation cycle of poverty. As providers, we need to work very hard to do this. You could ask, well, where would we find the money? I have arguments about money, but I would say one thing is for sure: We have overlapping systems where we waste a lot of resources. That is perhaps most true in medicine,

where we estimate the administrative cost in American medicine to be 20 to 25 percent higher than in Canada.

I am reminded of a story that a friend of mine told me about talking to Julius on a street corner in New York. They were near some kind of service agency. And Julius said, if we could just put all the resources of all these different, separate service agencies serving kids together in an integrated program, we would probably have enough money to take care of the children in New York City. We need to think about how to do that on our end as leaders and providers.

Finally, I would say we need a paradigm shift. Particularly in the United States, we have both legislatively and unethically made parents solely responsible for the long-term futures of their

children. My wife and I are parents. We have four children and whether my children have health insurance

We should be concerned about mental health insofar as it interferes with the appropriate developmental tasks of sitting still, learning to read, and so on.

or not depends on what kind of job I have and what kind of access I have to health insurance through that job. I don't think that makes any sense at all. We ought to be guaranteeing coverage for everyone. We ought to uncouple the responsibility, the long-term responsibility for children, from making it solely the parents' responsibility to making it a shared responsibility.

Unclaimed Children compelled us to learn that we can do much more, that we have the ideas. We need to figure out how to implement them. We have a long way to go, but we really can do this very differently.

One quality I particularly appreciated about Julius was his indefatigable optimism. He never stopped working. He never stopped fighting. It was very difficult to be in the Carter administration and then watch Reagan disassemble many of the great programs. It has been very difficult to watch many other things that have happened, but he never stopped having the larger vision, never stopped working on the ground to solve problems. So together, we can.

Marc S. Atkins, Ph.D.

Professor of Psychology in Psychiatry, Institute for Juvenile Research, University of Illinois at Chicago

I want to build on Bill Beardslee's comments about what a public health approach might look like. However, I will start by putting this in perspective. I have been thinking recently about the mental health parity law, which, obviously, is a terrific thing in many ways. But I am afraid that, because of the way that our system is set up—that is, the “no pharmaceutical left behind law”—that we have created a situation where we have become fully ensconced in the health system.

Here is a summary of a report from the China News Agency titled “China Gives Limited Approval to Western Medicine”:

“At the conclusion of a three-day meeting held in the Great Hall of the People in Beijing in March of 2001, an elite panel of 12 traditional Chinese medicine practitioners declared, ‘There's sufficient evidence of Western medicine's effectiveness to expand its use into traditional Chinese medicine and to encourage further studies of its physiology and clinical value.’ In particular, the panel's report stated, ‘Western medicine shows promise as adjunctive treatment

to traditional Chinese medicine. As a stand-alone medicine, however, its efficacy is mainly in the areas of acute and catastrophic care that comprise a relatively minor percentage of total patient complaints.’

“The consensus report was particularly critical of biomedical research designs since the panel had based their assessments solely on data from randomized controlled trials. Key points of their critique were:

“Biomedical trials are designed to determine the mean response to treatment. The outcome is of limited value to traditional Chinese medicine practitioners who are trained to devise individualized treatment protocols.

“Biomedical trials test one drug at a time. This approach is bound to reveal unwanted side effects, in contrast to traditional Chinese medicine, which seeks combinations of herbs to balance out adverse effects.

“Diseases chosen for study in biomedical research are too often imprecise collections of systems, such as irritable bowel syndrome, chronic fatigue syndrome, or attention-deficit/

hyperactivity disorder. These categorizations are lumped together and are different conditions that are readily distinguishable by traditional Chinese medicine diagnosis.

“It is also our impression that Western medicine is based on a belief system that is powerfully reinforced by the large sums of money



patients and insurance companies are willing to pay for treatment. We strongly recommend, the panel concluded, that patients should be treated with Western medicine only on a referral basis from a practitioner of traditional Chinese medicine.”

I am just going to make a few comments about what I think a public health framework might look like. I offer these to you to give some thought to whether we are giving enough attention to the problems in our current system, or whether we are simply trying to work around the edges of what we know is an appropriate way to understand children's mental health.

In my opinion, the person we need is Al Gore to be our spokesperson. But if I were to bring Al Gore up on the stage, it would not be to talk about mental health but to talk about ecological principles. There are a couple of things we know about children's behavior. We know that context drives behavior, which is to say that people operate differently in different contexts. We also know that there are multiple influences on behavior. We also know that there is a reciprocal relationship between individual behavior and context.

I do a lot of work in schools, and I am often asked to talk about children's aggression. One of my favorite ways to start is to ask the teacher whether they want me to talk about aggressive kids or aggressive settings. The teachers always ask, “What do you mean by aggressive settings?” That is what I want to get. I ask them: “What does your playground look like? What does your cafeteria look like?” What we know is that we can control a lot of behaviors through settings. I have this fantasy, that we are trying to operationalize our work in Chicago, that we can train mental health providers to walk in a room and not pick out the aggressive child but pick out the aggressive aspects of the setting.

I ask them: “What does your playground look like? What does your cafeteria look like?” What we know is that we can control a lot of behaviors through settings.

Ecology is the reciprocal relation among natural elements in an environment. The way I understand how that is operationalized for children's mental health is to consider the primary mission of the setting that we are concerned about and, in our case, we are working



a lot in schools. What is the primary mission of schools? It is learning. I will invoke another president and say, “Ask not what schools can

When we have a 20-year gap between research and practice, that is not a problem with practice, that is a problem with research.

do”—well you know what I am saying.

We then take these goals and ask ourselves, what are the mental health aspects of this? If you think about Head Start, you could easily

make a case that Head Start was the most important mental health program that has ever been devised, and the term “mental health” was not its key component. Of course, the reason is that it made kids smarter. It made parents smarter. It helped kids get a good start on schooling, and we know schooling is so critical.

So what we try to do when we go into schools or after-school programs is to consider what their goals are and, then, how we can help them accomplish their goals, because that’s the primary mental health goal. What we try to do is think about the mental health resources, be it the indigenous resources in that setting or the mental health staff who are in community settings, and try to figure out how we can reallocate those resources—not to diagnose kids, not to individualize treatments necessarily, but to support the setting’s goals.

We are always trying to think about sustainability. But we do not think about sustainability by thinking, “First, I build a model, show that it works under the conditions in which I control everything possible, and then I figure out later how I might get other people to use it.” That is a

failed mental health model, and it is a failed research model. When we have a 20-year gap, as it is estimated, between research and practice, that is not a problem with practice, that is a problem with research. That means we are designing the wrong studies under the wrong context for the wrong people.

What we need to do if we are serious about a public health framework, and we are really serious about advancing children’s public health, is to design new models of research that are going to move into practice more quickly. And, we are going to understand that practice does not mean individualized health care delivery in the way that our Western medicine system tells us. It should be a holistic approach and one that is integrated into children’s settings.

From a perspective of sustainability, I just want to offer a couple of definitions. One is the ability to maintain a certain rate or level. We need to think about whatever we are doing and whether it can be maintained at the same rate and at the same level. Largely, we have no research to support us doing it, and we need to start working on that issue.

Sustainability is also defined as serving an ecological balance by avoiding the depletion of natural resources. As I understand our work and the goal to advance a public health model, I ask us to think about how we can integrate ourselves into the fabric of children’s lives, rather than trying to come up with alternatives in our clinics and hospitals that, largely, will have a marginal effect on them.

Mary Jane Rotheram-Borus, Ph.D.

Director, UCLA Center for Community and Families; Bat-Yaacov Professor in Child Psychiatry and Biobehavioral Sciences, Semel Institute for Neuroscience

We heard Mrs. Carter and Marian Wright Edelman call for a number of new programs: universal access, all American families in non-stigmatizing environments that are developmentally linked and that are adapted to the local context. I would say there is a huge gap between what we heard or what we have experienced because while we say “universal,” we mean poor children in America. And while we say “wellness” and that we want everyone to strive to be their best, what we really mean is that we want children with disabilities to strive to be okay. While we say “non-stigmatizing environment,” all we talk about are institutional settings and, rather than mental health centers, we mean schools.

We talk about our theory that we are going to be driven by the needs, preferences, and desires of consumers and families, but we really design for providers. We do not even consider providers' capacity when we design our evidence-based program, or that our successes have, in some ways, narrowed our focus and narrowed our ability to see what our options are for the new paradigm. We cannot solve the problem alone about how to design a new paradigm for mental health services.

Every child in America is eating 10 percent of his or her meals at McDonald's. They are spending two to three hours a day on the Internet. YouTube, MySpace, and networking sites have a far bigger influence on children's lives than our evidence-based prevention programs do. And, while we have unclaimed children, we need to begin to design and to think about how we are going to achieve the impact markers that were outlined for us by our leaders yesterday.

In *Unclaimed Children*, we noted that we are way behind in technology, but recently we have seen the success, how technology and strategy worked together to mobilize our entire country. Barack Obama's success mobilized us in very

different ways; there wasn't one day in the last year that I didn't get 10 e-mails. But I have never been mobilized for prevention.

We have argued for wellness. We design, we fund, we advocate for our safety nets. We talk about all families, but we mean poor families. Last summer, it came to light that Los Angeles school districts have a 75 percent dropout rate among Latino children. That is bad if you are a poor family, and you live in the wrong neighborhood. But our poor institutions have an equally big impact on middle-class and rich families.

I grew up in L.A. We never thought of going to private schools. I went to Catholic school, which had nothing to do with money or the quality of the schools. But now you hear middle-class families trying to pay \$24,500 per year after taxes to

As evidence-based researchers for prevention, we have been like custom builders. We have designed our prevention programs to be holistic and they have gone nowhere.

get their child into private school. This elicits huge competition, turns mothers into chauffeurs, and requires significant limitations in high levels of what we are calling in the literature “concerted cultivation.” That if we design for the poor, it will never be generalized to the middle class. Unless we look at the spectrum of families in the middle class and design universal prevention services, we are going to have some of the same stumbling blocks that we have talked about.

Families go to three places to access resources: self-help groups, a 2-billion-dollar a year industry; pediatricians' offices where, if we look at the Academy of Pediatrics Guidelines, it would take pediatricians 80 minutes to even mention all the things that they are supposed to in your local health visit; and therapy, where the going rate is \$1,000 an hour. As evidence-based researchers for prevention, we have been like custom



builders. We have designed our prevention programs to be holistic, and they have gone nowhere.

In the business world we talk about business people in 1996 who gave us disruptive innovations. It means, rather than trying to be comprehensive and develop a system of care, we make a system that is simpler, accessible, sustainable, and good enough. We will not hit the needs of the kids with severe emotional disorders. But, we could hit more children with universal programs for a large section of all of what you would call mid-level or universal prevention programs. Doc-in-a-Box is an

example of a “minute clinic.” There are minute clinics in CVS and Walgreens stores. I would say private enterprise has a lot to teach us.

We are doing an experiment, funded by Robert Wood Johnson, to see if we can have mental health minute clinics. Our vision is family wellness centers in every shopping mall in America where families go four times a week. Can we synthesize our current evidence-based literature, but have our prevention programs for school transitions put in martial arts programs and delivered by martial arts experts or teachers or dancers? It is a different vision, but we need to challenge ourselves to make this new paradigm.

Discussion

M. Atkins: I am struck by the symmetry of our comments, this integration into ongoing practices, as opposed to setting up separate systems. But, how do we move this forward? Can we really transform the current system? I am trying to co-opt the current system, bring folks into schools and into after-school programs and force them to think differently. Is that a practical way to go? Is there an alternative way?

M.R. Borus: Actually, I don't know the right solution. You are going about doing what we are currently doing better in an incremental improvement, a quality improvement model over time. They are really not in our existing system, but there are huge resources out there. People are influencing our lives in really major ways every day, and we are not utilizing those systems to meet our goals. Our private enterprises, our corporations—America's capitalism—we do not use that system to meet our pro-social goals. I would like to see us use those more, but that means we do our business very differently than we have in the past.

W. Beardslee: What would be an example?

M.R. Borus: Take an evidence-based intervention. Right now, you have to first have a design, and it has to be theory based. Then, you move to efficacy trials, and the dissemination guarantees that it is going to be 15 to 20 years before we can go out with any evidence. With disruptive innovations, you can evaluate whether they work after they are there for about five years.

You are going forward on the best of science, which we are doing anyway, every day of the week. We do not have an evidence base for a large number of programs. But, we have been encouraged to brand ourselves on the basis of our research and that is what depression researchers do, what parenting prevention programs do. We share much more in common than that which makes us distinct. If we started

building on common foundations, a common set of skills, and tailored only to the specific, developmentally linked prevention challenge, we would be in a very different ballpark for diffusion.

M. Atkins: I have heard people say the world has problems and the universities have departments. What I enjoy about working in schools is it forces me to be real. Schools can't afford to say, "Sorry, we are not going to deal with the most severe kids." They tried that, but they are legally mandated, and they have all sorts of ways of trying to get around it. But the mental health system can just say, "Sorry, we are not going to do that today. We do not treat autism in our clinic." Schools can't do that; they are mandated to take everyone. And I think that normative perspective is what we are missing in mental health.

I would like to think that social workers lead us. Jane Addams and others have taught us so much about that. Get back to those principles again, and get us out of these hospitals and clinics and these ridiculous settings that nobody wants to go to, and force us to be normative, take the problems in context, and not slice them and dice them so that we can study them more conveniently.

W. Beardslee: Mary Jane is making the innovation dissemination argument that we have to go very differently than we have. If we stick with the regular paradigm, it will go much too slowly. Marc is making the ecological argument. I agree with both of those. The problem that I have with what Mary Jane said, not that I disagree, is that I do not know how to go about it in the most effective way.

Let me give you two illustrations. The reason why I said disadvantaged children or unclaimed children have compelled us to learn, is that in the history of social movements, it is very often that the most effective programs are devised for the poor and then generalized. I work in a

Discussion

children's hospital. In the 18th century, children of rich people were cared for at home. At a certain point, hospitals for poor children began and then became children's hospitals. Now, we have children's hospitals that are for everyone. So, again, the Boy Scouts were founded as an organization to help poor children, and now it is an organization for all children.

When I was arguing that we needed to study and learn from the comprehensive integrative approach that poor families need, I was arguing that that is the approach we are going to come to for all families, and that has been absolutely clear in health care. The part that is hard for me about disruptive technologies is that my profession has been co-opted by the pharmaceutical industry so that they are using all kinds of technologies to sell drugs. In Massachusetts, we routinely see ads on TV for antidepressants, for insomnia medications, and so on, to go far, far beyond the data. How do you use the technology and maintain your integrity when most of the uses of the technology have been for commercial gain?



Mrs. Carter with Janice Cooper (to the left of Mrs. Carter) of the National Center for Children in Poverty and some of the NCCP staff.

RESPONDENTS

Robert Friedman, Ph.D.

Professor, Child and Family Studies, Louise de la Parte Florida Mental Health Institute, University of South Florida

Right now, we are working on issues, on how to do it better. Part of that is, how do we go to scale? How do we get effective systems of care that will provide access to effective care for all children in a manner consistent with system of care values and principles?

Issues

Implementation

The technology of implementation is learning how we can work within communities to make something effective. How do we provide the supports, the technical assistance? How do we mobilize the social, intellectual, and fiscal capital within communities to make something work? The implementation field is a growing field, a new field, and a very, very important field.

Leverage

We are at a time of tight resources. We have to look at how, for every dollar we spend, we can get \$10 worth of return. How can we enhance and multiply the benefit from our actions and our successes? This is well addressed in the new book "Forces for Good" that looks at effective nonprofits. Effective nonprofits that really maximize their impact have learned how to leverage their resources.

Marketing

I hear a frustration that the general public and general society do not recognize the importance of the mental health needs of children and families, that we talk to ourselves. We have not effectively marketed the importance of this issue to important key audiences. And those key audiences can be the business community. It could be the religious community.

It could be the legislative community. We have not gotten our messages across in a powerful way. I think we need to learn more about how to market. The social marketing field is important. I learned a new term called "experiential marketing" that really helps bring home the message in a much more powerful way to communities by getting people involved in ways that allow them to experience the problems and not just read about or hear about them secondhand.

What We Need To Do

As we move to a public health model, as we move to expand our efforts, I hope that we will continue to talk about a broad view of the needs of children, and a broad view of what we need to do, and not just focus on how we prevent diagnosable mental health disorders. We need to be talking holistically, and I think that has been a consistent theme.

We also need to change our unit of analysis. We need to keep some of the things we are doing—we are very focused on services, we are very focused on programs. That is important, but I think our unit of analysis also has to shift to be a community level of analysis. We need to know how well we are doing in communities, to be able to identify the ones that are putting it all together, doing it all well, and see what we can learn from them. We need to learn how we can build the capacity.

Communities are not sitting there idle, just waiting for us at the federal and state policy levels to make great decrees so that they can do things. Communities have tremendous energy and tremendous resources, and we need to figure out how to support that and learn from that. Our science has to figure out how to do that.

We have talked about being science based, and I think that is important, but we need all kinds of knowledge development activities. At a clinical and programmatic level, it may be appropriate to do randomized clinical trials, but I think that sometimes, our focus on randomized clinical trials helps create a focus on the program level rather than on the whole system and on the whole community level, where the randomized clinical trial model just does not work.

In addition to being science driven, we have to be data driven. We have to look at how communities develop practical, useful markers of how well we are serving and supporting our kids. We need to look at how we can use that data in a kind of continuous, quality improvement way.

We need to move beyond just experimental research. I find more and more useful research that identifies successes in the business world, in the nonprofit world, in the child development world, that looks at communities and looks at systems and, somehow, despite the obstacles that we are very good at citing, have been able to achieve great success. They don't lend themselves to research, to experimentation. They are natural experiments and opportunities for observational learning. This rich, descriptive,

We need to become much more systems thinkers, to look at the connection between different factors, and measure how we integrate.

contextually and culturally oriented learning is about how the forces have come together in communities and what we can learn.

Not so we can go into another community and precisely replicate it, but so that we can extract some general principles that can help us in our efforts to broaden what we do.

We are dealing with complex problems. We need to develop methods to help us learn how to be more innovative. I am very pleased with the contributions that complexity science, a relatively new field, has made to help us conceptualize what we are doing and to help us distinguish complicated issues from the really complex issues. We need to examine our mental

models and look at how we are thinking about issues. We need to become systems thinkers, to look at the connection between different factors, and measure how we integrate them.

We need to be much more transdisciplinary and involve other disciplines that can help us. We have had great contributions from understanding theories of change and helping us to look at what our thinking is and how we plan to make the change. We need to study much more of what it takes to produce system change. The field of bringing about system change goes beyond any single discipline, beyond what many of us have studied and learned. And, if we are going to become effective at this, we are talking about not just developing new programs but about becoming effective system change agents.

We need to recognize that improving the health and well-being of our kids is more than improving our health care systems. Improving our health care systems and our mental health system is an important part of it, having more services and supports. But, creating communities and cultures that support families, providing the opportunities for their success, providing the opportunities for connections in their communities, and providing the opportunity for academic success are critical, too. We can probably achieve more on behalf of kids and families by doing those than anything else.

We know much more than we are applying. We also have to be realistic and look at our mental health models, our framework, and be willing to change what we are doing. While we are doing that, we also have to build on our successes, on what we are doing, and figure out how to bring together the public health focus, and the system of care focus, and the evidence-based practice focus with data-driven approaches. We have to figure out how to be genuinely holistic, how to be multisystemic, and work at the local community level, the state level, and the federal level. We have an enormous challenge ahead but we also have had great successes and we have much to build on.

Danielle Laraque, M.D.

Professor of Pediatrics, Mount Sinai School of Medicine; President-Elect, Academic Pediatric Association; Vice Chair, American Academy of Pediatrics District II, New York

I am a pediatrician and, in terms of discussion about children's health and children's mental health, I think my primary mental health role is the development of a sustained relationship with a family and with a community. That is what we are talking about, how we understand the context of care and the context of the lives of children, and how we address their needs in a holistic way.

My experience in the last 20 plus years has been in the Harlem community. I started in Central Harlem first and, then, in East Harlem. When I first went to Central Harlem, I was amazed by some of the assumptions that were made about the relationship of clinician to family. Many of us abolished those assumptions—that they would not be longitudinal, that they would not be a total investment in the care of all children.

I think we have to start from the new framework in how we respect families, how we respect the children that we are serving—and we are here to serve—and how we respect the community. So I am going to relay some thoughts in terms of reviewing some of this literature that we all know but that we need to conceptualize to bring our policies forward.

Mental health issues are common in primary care. So, the absence of dialogue with primary care is not only unacceptable, it makes no sense. My role as a pediatrician is to be invested in the lives of the children whom I serve. We must be at the table, and we are the driving force of this in terms of a system, in terms of building sustainable relationships. The Institute of Medicine report, "Children's Health, the Nation's Wealth," spoke to a new conceptualization of child health. It says threats to a healthy child are seen as compliance interaction of the things we know: biological, behavioral, social, and physical environments.

We also have been talking in the last decade or so about adverse childhood events. So we are talking about genetics, about the social environment. But what does that mean? We

know that our policies help to guide this, but let me share with you what it means to me at the family level.

If you ask me how I address the mental health needs of children who come to see me in my practice and in the community, I say I talk to them. I listen carefully. I relate to the families. I have not walked in their shoes; I make no assumptions about their values, their families, their children, or their community.

I do listen to children. Recently, we have been talking a lot about what exposure to violence means to kids, and we know it has negative effects on their lives, certainly in terms of their attachments, development of depression, anxiety, and posttraumatic stress. But, what does it mean if we meet with a child and the child's family and do not ask about these exposures, about the context in which they

live, about domestic violence and sexual and physical abuse? We also do not ask what makes their lives pleasurable, what gives them strength.

We are a deficit model and not focused on strengths. We must embed within our practices, our community, and with our services this approach of respect in relationships to an ongoing relationship and the fact that we are here to serve.

The American Academy of Pediatrics and the Academic Pediatric Association that I represent have certainly talked about the multitude of things that we need to do as clinicians. Community pediatrics, what is that? It is a perspective that enlarges the pediatrician's focus from one child to all children. We consider context that includes the leading causes of morbidity and mortality in a community. We look at disparities in care and why they arise. We look at needs assessments, and we look at community resources and assets from a cultural framework.

Mental health issues are common in primary care. So, the absence of dialogue with primary care is not only unacceptable, it makes no sense.

I went to Central Harlem in 1986 as junior faculty. We were hit by various epidemics: crack cocaine, HIV, and gunshot injuries to kids. So what can we do as professionals? Well, we have our professional knowledge, our academic knowledge, and we must use that in helpful ways. What we did in Central Harlem was to partner with families and communities and say, this is what we bring to the table. We bring our data, so we are data driven. We look at the epidemiology of injuries to kids. In 1993, we hit the peak in firearm injuries leading to kids' deaths. For adults and kids, the toll was 40,000; the toll over the course of the Vietnam War was 58,000. Every two years, we were losing more lives than we had lost in Vietnam.

We knew the data, we collected the data, and that was important to form a discussion. But, what we did in our community was not be paralyzed by statistics. We had a marvelous transformation in the Central Harlem community, and that transformation did not come from us the clinicians and the epidemiologists. It came at the base of this community. We partnered with communities. We had not had a Little League in Harlem in 30 years, and the

We developed a community approach that teamed our knowledge and our science base with community activism. This is community pediatrics.

parents there demanded to go forward. But, they said, there is data that we do not have. We want to tell the

Parks Department that we cannot use these parks. There are hazards there; children get injured. There were no useful playgrounds, so children played in the streets, and our motor vehicle injury rates were sky high. So we developed a community approach that teamed our knowledge and our science with community activism. This is community pediatrics.



Mental health and learning cannot be disentangled. The opportunity for primary care is a longitudinal relationship that gives us the benefit of following children from birth to age 25. It is hard for us to let go of them. In New York state, we have 4.5 million kids and the tip of that iceberg is about 200,000.

We are not identifying children at risk so that we may begin to intervene early. The bigger part of the funnel is where we need to focus on strength-based approaches, youth development, and resiliency. No child fits into just one of those slices. They are in all of those slices, so children with severe emotional disorders are children who need support in terms of resiliency, youth development, after-school programs, and daycares. Children who have serious emotional disorders may not be engaging in substance use but, in fact, need to have those risks identified.

I am going to tell you one story. Four-week-old Justice was admitted with an acute history of vomiting and was noted to be less than birth weight. Child Protective Services accompanied the mother and child, a child we took care of. This 19-year-old mother had bipolar disorder and attention-deficit/hyperactivity disorder with the onset at 14 years of age, which is typical, and the age when she had her first suicide attempt. During the pregnancy with this child she again attempted suicide. Currently, she is on no medications and not receiving care. She has

another child who is 14 months old, and she lives in a domestic violence shelter. This is not an unusual story for us in primary care.

Reflect with me on a community pediatrics approach: What supports a medical home? What supports a longitudinal relationship and the quality of care through quality chronic care models that have shown us how to apply the evidence? We identified a medical home for these two children and young mother. We provide the longitudinal relationship. We do know that nurse partnership home visitation programs have been shown to be effective in improving both maternal and child outcomes. Postpartum assessments of this mother and monitoring of her psychiatric access to evidence-based treatment is critically important, as is referral to early intervention for both children for developmental, social and emotional screening.

But, screening must be tied to linkage to effective services, and to detection of exposure to trauma, such as domestic violence.

Integration of social, emotional, and physical health, and monitoring of growth and development—that is my job as a pediatrician. That is all of our jobs, finding supportive services for this adolescent and attending to her educational needs.

In Harlem, our kids told us that they do not want to talk about violence, they do not want to talk about sexually transmitted diseases. They do want to talk about education. And, if we do not meet them where they are, and where their needs are—assessment of a family's strengths, victims' advocacy, care coordination, and longitudinal relationships—we will have missed the boat. We should not call our children unclaimed children. We claim all of our children because we must provide the solutions and, if we do not, we become irrelevant as professionals to their lives.

Deborah Perry, Ph.D.

Assistant Professor, Johns Hopkins Bloomberg School of Public Health, Department of Population, Family and Reproductive Health

There is very broad consensus here that we need to shift the paradigm in terms of children's mental health. Everyone, one way or another, has talked about what his or her version of a public health framework would be. And when I hear these comments, I actually hear two rather distinct but complementary strategies.

The first strategy is the need to encourage our health systems to adopt public health principles. And, as someone who is in a school of public health, I view public health through a particular lens, through my training and from my colleagues.

The second, though, is to infuse mental health principles into public health settings. I want to talk about each of those two things and how they complement each other. I think the nice thing about this is that different people will be able to take the lead on different parts of this, and that we have had nice diversity in how people have thought about this.

We all agree that the mental health system needs to adopt public health principles. When we think about what those principles are specifically, one of them that we have heard a lot about is a population focus. That is really at the core of what public health is, taking a population focus. It means all kids, and it means we need to shift away from the focus that children's mental health has taken over the last 25 years, which is focusing primarily on the needs of adolescents and those who have been diagnosed with a serious emotional disturbance.

That has been what catalyzed some of the early children's mental health movement; so, shifting away from that without leaving that behind is a really important piece that we need to keep in our minds.

Maternal depression affects young children's development and their mental health. Those are intricately related.

The corollary of that is expanding the continuum from a focus mostly on treatment to much more about prevention but, then, even more so about the promotion of good mental health. I see that continuum as part of that population focus but not the same thing. Both of these things require us to move away from the identified patient model. We need to move away from diagnosis-driven systems, away from systems that separate children's and adults' mental health because, particularly in young children, you cannot separate those two things, although that is true pretty much across the developmental spectrum. Maternal depression affects young children's development and their mental health. Those are intricately related.

The other thing researchers want to do, when we do our randomized controlled trials, is to enroll people in a prevention trial. We focus only on those people who are at high risk for depression, for example, and we screen out everybody else who might have one of those complicated co-morbidities like substance abuse



or domestic violence, because we are really trying to get at what works for depression. I think we definitely need to move away from that.

I do not think we have thought as much about how to really do this and, I think this is what the panel was really struggling with. For example, what is the mental health parallel to fluoride in the water? What would that look like? What is something that we really would give to everybody that would be a universal intervention? We know that the lack of folic acid early in pregnancy leads to neural tube defects, so we have fortified food with folic acid. How do we do that kind of thing for mental health?

Public health is very proud of its efforts to reduce tobacco use. That kind of example really tells us that, not only do we have to have effective interventions at the individual level for people who are currently smokers, but we have to do a lot of things that change the way people think about smoking. We see those people out in the cold smoking because they have been moved out of buildings—you know you can't even stand in the doorway anymore if you are a smoker. We have used tobacco taxes. We have used lawsuits to get money for prevention, and it has been a whole range of strategies that really has allowed us to shift the curve in terms of tobacco use.

We need to look at the issues public health brings us; we need to look at disparities and access and outcomes for racial and ethnic groups but, also, by class. Bringing a public health approach to mental health forces us to do that better and in a more intentional way.

Bob Friedman really articulated what we know are mental health values and principles. Those are system-of-care values many of us are familiar with: family and youth driven; cultural and linguistic competence; and community based. These are things that mental health professionals take for granted, but this is not how everyone else views the world. As we start to find out where children and families really are, those settings where people are, we can infuse those principles into those settings.

Jane Knitzer mentioned "being developmentally appropriate." That is a principle, a value that we bring to our systems. The piece that we all know but have not said out loud yet

is “relationship based.” This is one of those principles that we need to bring to our mental health systems.

In prenatal care, we are testing how you embed a cognitive behavioral therapy model to prevent postpartum depression. We are doing that in home visitation with both treatment and prevention. We are doing mental health consultation in early care and education settings, so we need to do much more embedding of those services within those settings.

What Do We Do From Here?

I think we need to take up Jane Knitzer’s charge to create a 21st-century legislative framework for mental health, and we certainly need to think about how we make this population focus real again, without leaving behind all the work that

we have done on behalf of those children who do have a diagnosis and who have complicated needs. We need to think much more about intentional strategies for reducing disparities in terms of access and outcomes, and I think we are going to learn some of this from Project Launch and from the early childhood systems of care sites that have been funded recently by SAMHSA.

We need to figure out what these constructs mean and make sure we are talking about the same things, because we are going to bring in a whole diverse group of people. My colleagues at Georgetown and the Technical Assistance Center for Children’s Mental Health are issuing a monograph on a public health approach. We need to work together to try to figure out what that really means in terms of a public health approach for children’s mental health.

PANEL III: POLICY BARRIERS AND OPPORTUNITIES

Richard Frank, Ph.D.

Margaret T. Morris Professor of Health Economics, Department of Health Care Policy, Harvard Medical School

Economists have a policy arsenal that they bring to economic policy issues in moving children's mental health care. It involves payment and measurement, but it also involves regulation.

When you scan the environment and think about children's mental health policy issues, the economic issues play out fairly differently across different dimensions of the children's mental health system. You can look at regulatory and accountability issues, and the incentives they create, to under-recognize and under-attend to children's mental health care issues in early childhood.

On the other hand, if you look at questions around severely emotionally disturbed children, and you look at payment arrangements there, you see that there are certain historical patterns locked in that are very hard to change. Looking at the primary care sector and what we just heard about in the last set of comments, you see that, very often, we have organized our care delivery organizations in a way that is fundamentally inconsistent with putting evidence-based treatments into place. They play out differently.

Before we get into the issues in earnest, I just want to put a couple of presumptions on the table. When people start thinking about economics and what economics has to say about policy issues, they quickly get to the business case, which I think is generally inappropriate here, but certainly inconsistent with economic analysis. Economics begins with the idea that children's mental health is valuable in its own right. Therefore, you do not have to pass a will-it-pay-for-itself test when you propose to do something new. If you want to do the economics, you ask what are the benefits. You count all the social benefits and the cost, then, you try to do a balancing. That is fundamentally different from asking whether something will pay for itself.

Having said that, budgets are real and public budgets are especially real. Households and citizens don't like to see those expand dramatically. What we have is finite budgets. Now, what that

means is that, even if something passes the social cost-benefit test, it does not mean that it is necessarily going to happen because you have real budget concerns. And, what that means is that, as a policy matter, even though you have a good idea and it is the right thing to do, it is not going to happen unless you find a distortion somewhere where you can save some money and put it to work in a different way.

Given the current economic climate, we cannot expect huge growth in public budgets. We will probably have some retrenchments, at least in a growth-adjusted way. One exception to that is parity. This is a terrific year because we have enacted parity after many years of trying. It is particularly significant in the context of children's mental health and especially in the context of the State Children's Health Insurance Program (SCHIP).



Three Issues

I want to touch on three main issues. One is the underprivileged of mental health services related to early childhood, and I will focus on pre-K and Head Start. Then, I want to talk about distortion, which is an opportunity for some savings and perhaps some redistribution, and about the apparent overemphasis on institutional care, particularly for treating serious emotional disorders (SED). Finally, I will come to the parity opportunity.

Underprivileged of Mental Health Services

What is striking about the first Unclaimed Children report, and then this new report is that they start off by highlighting all the things we have learned about the biological and social forces that are influencing child development. We really have gotten a lot smarter about this. Building on that was the “Neurons to Neighborhoods” study, which started to highlight the importance of mental health issues in the brain physical development and the development of young children.

Economists, always slightly slow to the barricades, have responded to this. Systematically and thoughtfully, Nobel laureate James Heckman and others have started mapping out the economic consequences of differing developmental paths that tie together the best of what we know in neuroscience with what we have been learning about the economics of human capital. Heckman’s work has shown how the research results on neuroscience and early childhood development really are the fundamental economic building blocks for human capital and economic capabilities in our society.

Child care and early childhood education, in and out of the home, are key buffers for environmental insults. “Neurons to Neighborhoods” and other neuroscience has really focused on toxic stress. But the mental health of the household is key in the formation of economic capabilities in young children and that works directly through the way the family learns and understands how to deal with child development as well as through the family member’s own mental health.

Family mental health and, particularly, maternal health affect child-caring capabilities indirectly and directly, and have an influence on the young child. All of this affects learning, behavior, resiliency, and memory, all of which turn out to be strong predictors of what happens in the human capital development process and, ultimately, in the human capital stock that you see in young adults as they enter the labor force. These are critical building blocks. It is the intersection of neuroscience and the economics of human capital that is starting to give us new ways to think about intervention and also the payoff to investment.

I want to highlight very briefly some research from this line of thinking. Table 1 in my presentation shows the results from a lot of econometrics razzle-dazzle applied to a national longitudinal survey of youth, tracking mothers and children over time. It shows a comparison of the difference in the behavioral problems index for families where the mothers are not depressed, compared to families where the mothers are depressed, holding constant everything that you can imagine, from IQ to parental education to family structure and family size. The seven-point difference is statistically meaningful; it is about one-third to one-half of a standard deviation.

Also notable is what it takes, in terms of family income, to produce a similar difference in the behavioral problem index. You get roughly a similar decline in the behavioral problem index by going from an income of about \$35,000 to an income of \$75,000, holding constant all those other factors. That starts to give you an idea. If you were to give families the capability to buy out of the disruption that depression creates, you would need an income of about \$40,000 to do that. That does not mean that you spend it all on mental health but, in general, that is what it would take.

It is the intersection of neuroscience and the economics of human capital that is starting to give us new ways to think about intervention and also the payoff to investment.

Financial Incentives

Let me tell you a little story of a Head Start program in a mid-size city somewhere off the

coast in the United States. This is a place where the program leadership is committed and innovative, and where they are always trying to learn and read and do things that are new and good. They contract for mental health services when children are identified with diagnosable problems and when parents are sometimes identified with diagnosable problems. They also have very high rates of behavioral problems in the classroom.

The turnover rate for classroom teachers is about 35 percent across the programs they run. It ranges from as high as 60 percent in some of the programs to a little under 30 percent in others. When they do focus groups and exit interviews, behavior problems in children are consistently identified as the main reason for the turnover. It disrupts learning and it disrupts the ability to run a program. Two possible fixes are simple and evidence-based: teacher training in behavior management and screening of families for mental health and substance abuse.

Their solution was to put in a screening program that is likely to identify families with children who have behavioral problems and to put them on the waiting list. The bottom line there is that the behavior management and the family mental health issues are much easier to avoid, and less costly, than they would be if a program was put into place to address these issues. There is a place where you see private incentives and social incentives as parting company, and so there is a wedge between what is in our society's interest economically and what is in the economic interest of the organizations that we delegated the job of caring for these children. This is a serious policy problem.

Why is this? First of all, we do not emphasize mental health in positive ways in regulations, measurements, and accountability systems. Head Start programs have a huge list of things that they have to do. Mental health is in there, but it is not a particularly prominent piece. Second, we make it extraordinarily easy to do the wrong thing and to avoid the problem. There is no penalty, just a gain, when you have a waiting list for avoiding these students. They are costly, they lead you to larger subcontracts. There are all sorts of reasons to avoid them on the private basis unless you change the rules so it is no longer appropriate to do that.

I hope I leave you with the implications that there are tremendous payoffs to expanded child and family mental health investments in early childhood and that this is likely to be a good deal. The more we learn, the more the evidence suggests that this is a really good social investment. Moreover, trying to undo it later is more costly. It is not that it is not doable; it is just more expensive to do.

Third, financial incentives could be used to encourage socially efficient program choices. I will bet you that I could get the program director's attention if I told him, in this case, that he would get less money per child for those who do not have mental health problems and he would get more money per enrolled child for kids who do have mental health problems. Then, you start to realign the incentives so that society and private organizations are pulling in the same direction.

My research hypothesis here is that one of the underlying reasons that you see modest Head Start impacts is due partially to the fact that, on average, these programs tend to under-attend to mental health issues. If you controlled for the uncontrolled mental health problems, you would probably see a bigger impact of Head Start, a hypothesis worth looking at.

Distortion

Let me start by taking a quote from *Unclaimed Children Revisited*:

“The fiscal framework favors residential treatment. Consequently, there is an over-reliance on residential treatment that lacks an evidence base. The second is money and then the programs refuse to reconfigure their business models.”

This is a widely held point of view, and I think there is evidence to back it up. What I would like to do is to look at the last part of that statement and think about what it means because, in a sense, that statement is blaming somebody.

Comedian and actor Chris Rock does this wonderful little routine where he is commenting on the mauling of Roy Horn, of Siegfried and Roy, by a tiger in Las Vegas. Rock says he is often asked whether he was surprised by the fact that

this tiger mauled Roy. He says, not at all because the tiger was just being a tiger. What surprises him is that they get a tiger onto a tricycle and put a little fireman's hat on him and get him to go around the ring.

The point here is that, if you set up the rules so that it is a profit-maximizing, efficient, best-reimbursement policy to use the most intensive high-end treatments, whether or not they are evidence-based, that is what you will get. It is not their fault if you are not changing the business model. It is our fault for not changing the rules. While I think the statement here is an important, positive message about the policy direction, I think we need to think hard about how we go about fixing things.

What are the sources of this distortion where we are spending somewhere between 35 and 55 percent of our money on the most restrictive forms of treatment? History is obviously a big part of it. But, history is hard to change because it involves people's livelihoods, longstanding relationships, and regulatory structures, and all of those are hard to change. There continues to be a lot of concern in the community about safety, about the ability to cope with complex and difficult situations, and the availability of resources and the complexity of treatment programs all play into this.

Incentives

Every proposal made and every solution involves some form of flexibility in funding, flexibility in spending on service components. Usually, it involves identifying the fact that you need to go beyond the traditional clinical definitions of services. This implies a lot of discretion and a lot of delegation to providers or provider organizations, which then creates an accountability issue.

On the one hand, we are stuck with a desire to give people a lot more flexibility and a lot more discretion. On the one other hand, we are in a world where, for years, we have identified the delivery system as not doing what it knows is best to do. If you talk to providers, they really care. Generally, they believe that they are doing a good job or doing the best they can and, therefore, they are doing what they have learned in school. In fact, they wind up being like Frank Sinatra: They are all doing it their way. Doing it

their way isn't necessarily the evidence-based way, nor is it necessarily going to get children better. What we need to do is think about balancing the incentives and accountability.

Bundling

Bundling is clearly the way to go if you want to create flexibility. It allows us to change the financial hydraulics in a way that increases flexibility, encourages less restrictive forms of treatment, and promotes economic efficiency. However, it requires identifying somebody who is going to receive the money, or the bundle, and then do good things with it. We do not have a lot of those organizations. Usually, they have to be vertically integrated and broad-based.

Bundling can also be done at the individual level through voucher systems. But, again, you need the capabilities and the programs. You need the kind of care management that will bring it all together. None of that is easy to do.

Starting to get the incentives right or moving in the right direction is not enough. Our experiences with prospective payment, capitation, and pay for performance all suggest that you start loading up high-powered incentives into these payment systems. You move the world but very often it produces as many negative outcomes as positive outcomes.

Do not load up on one particular thing. Do not go just with prospective payment or bundle payments. Create five or six or eight policy instruments and do a little bit on each one that is pushing in the same direction. Look at the way businesses deal with trying to improve performance and trying to restructure. They will measure differently, they will organize differently, they will pay differently, and they will ask their customers to behave differently.

At the end of the day, all of those things start to push you in the right direction but none have super powerful incentives that can push you in both bad and good directions. They are all doing a little bit and each has a different constellation of outcomes. That way, you tend to get somewhat better balanced systems. Smart cost sharing, where you cover people better for evidence-based treatment; mixed payment systems, where you attenuate selection incentives, bonuses, and

penalties; accountability; management; and measurement of process and performance are all important elements.

Parity

SCHIP plans in many states are mirrors of the private health insurance system and that is partly by design. Parity imposes new binding constraints on the benchmark plan. So, if you are choosing your local HMO or Blue Cross plan or state employees' plan as your benchmark plan, when parity goes into effect each of those plans are going to have a much higher level of mental health care.

The Federal Employees Health Benefit Program experience of parity shows us:

- There will be an increase in the amount of management that is applied to mental health care.
- Financial protection of the sickest people will improve dramatically.
- There is not much change in access, although I think this might be different in SCHIP.

The SCHIP population has relatively high prevalence. The incomes are relatively low and, very often, families have a great deal of mental health needs. I suspect that the reauthorization of SCHIP will expand the parent-family links, which will provide a further leveraging of the parity method.

Policy Response: The Honorable Karen Bass

Speaker of the Assembly, California State Assembly

I have been a lifelong activist, involved out of concern with the war on drugs, the crack cocaine epidemic, and with how our country and my city of Los Angeles were interpreting what we should do to address the drug problem, which was to criminalize what I felt was a public health problem. So, I come to this not only as a lifelong activist but also as a public health professional.

This means that the design of the behavioral health care arrangements and contracts can be used to promote financing and organizational realignment. This is where we can right one of the imbalances, that distortion between pharmacotherapy and psychosocial treatments. By bringing the pharmacy benefit into the carve-out, you are likely to get a better balance. This is an opportunity to bring new principles and new learning to what will be an enriched benefit.

In a world of fixed budgets, highest payoff activities need to be identified. Early childhood prevention and treatment appears to be extraordinarily undervalued. It seems to be a high payoff activity about which policy-makers and payers need to be educated. If this holds up, regulation payment incentives and technical support can be used to align social and programmatic goals.

Funding distortions create opportunities for finding a pot of money that may not otherwise exist to realign, and they can be realigned on two margins. One margin is moving some of that money into neglected high payoff areas. The other one is doing things differently with the money that you have been targeting toward particular population, which, in this case, is the SED population. I think you can work on both of those margins, that there are some opportunities. Science is helping us. Parity is helping us. So, I remain optimistic, even though my 401(k) has gone to hell in a hand basket.

Twenty years later, we are dealing with massive incarceration in many of our states, and California is the leader. We are trained, very educated, and we think that the best way to bring about change in public policy is by bringing the research forward, by talking about how things are cost-effective. But really, I think the way you bring about change is through organizing and public pressure, and that is something that keeps policy-makers' feet to the fire and holds them accountable.

This creates a tremendous opportunity for us to figure out, after a presidential election, after millions of people participated, what happens to all of those folks. How do we capture and take advantage of that energy to build on the movement that all of us are participating in, the movement for universal health care and furthering the agenda of parity?

We elect people to office and expect them to bring about miracles. Because of term limits in my state, people cycle in and out of office in six years. We spend time educating officials and then they leave, and we have to start all over again. So, we decided to organize on a community level and bring someone into office. We built a precinct operation and impacted elections that way.

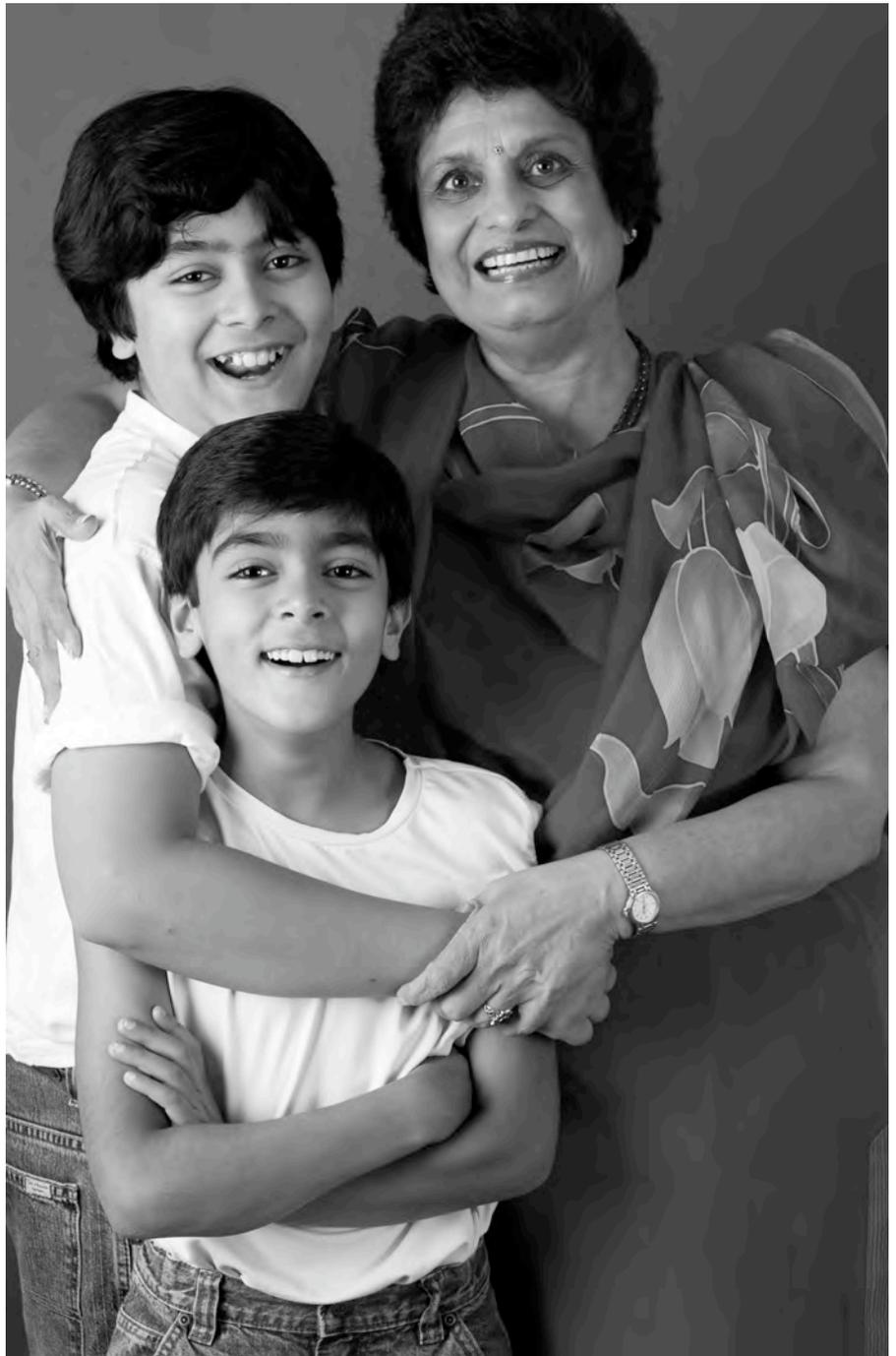
Switching roles has been very interesting, having spent much of my time protesting elected officials and, now, being one and trying to take the experiences of an organizer into the State House. Given that I knew I was only going to be in office for a short time, I wanted to figure out what I could accomplish by the time I left in six years. I decided to focus on the issue of foster care because it is one of those few issues that you can actually bring Democrats and Republicans together on, because people do understand and feel sympathetic for the plight of foster children.

The area I wanted to address was that of the relatives who take care of kids in foster care. A lot of the policy-makers, the bureaucrats who work in the different departments, have the view that "the apple doesn't fall far from the tree." How can you really expect these grandmothers to take care of these children when they messed up their own? That is terribly sad because that is not what happens.

I brought 200 grandmothers to Sacramento and let the elected and appointed officials hear what those grandmothers had to say, and we were able to shift that thinking. It was not because we presented them with

research, but because we presented them with 200 grandmothers who told their stories and that was very compelling.

I also did a number of focus groups up and down the state, because one of the basic principles of organizing is that you go to the people who are most affected by the problem. You involve them in identifying the solution and then empower them.



It was troubling to me to sit with a group of children in the foster care system who pleaded with me to figure out how to get them off of all the medication they were on, that they felt that they were very much overmedicated. There was some incentive in diagnosing them with mental health problems. I am not saying that they did not have them. But, when the kids moved from group home or foster home to foster home, the medications changed. I went to court to see how that was done. The psychiatrist in the courtroom would decide about the medication that the child was receiving. But that psychiatrist was not the same doctor who had examined the child in the foster home.

In California, we were able to pass legislation to establish a Child Welfare Council. Like many states, we have all of the silos, different departments and agencies that interact with the same population. With a Child Welfare Council, we now have all of the agencies and departments sitting in one room.

One of the things that I hope to do before I leave office is a ballot initiative where we can come up with a permanent funding stream for foster care, very similar to what was done in my

When you are thinking about changing policy, I really believe that mobilizing and organizing people is what truly makes the biggest difference.

state around mental health services. Proposition 63 established a tax on people whose income is one million dollars and above and that has developed a permanent funding stream for mental health. You do not pay taxes on candy with sugar in California, but you do on sugarless candy. So, if we close that loophole, I can raise about \$400 million a year. I am talking to the candy industry now to convince them not to oppose it, to maybe even champion it. We want the resources dedicated to aggressive prevention and intervention on the front end.

There is a program in Compton, Calif., called Shields, where they have been able to reduce the number of kids who enter the system by keeping the family together. We know that the main reason why children are in foster care is neglect, which is secondary to substance abuse. Shields keeps the mother and children together while mom goes through substance abuse treatment and the children receive counseling and education and whatever they need.

When you are meeting with elected officials, appealing your case to get legislation passed, the substance, research, and the evidence are nice, but they are secondary. What is important is how the elected official can use the issue in the future.

California has an \$11 billion budget deficit. In the next 20 months, that deficit could grow to \$28 billion. It takes a two-thirds vote to pass a budget in California and, unfortunately, my colleagues on the other side of the aisle are adamantly opposed to raising revenue. Over the last few years, we have had to cut out \$15 billion. We have cut away the meat and the fat and we are down to the bone. We really cannot afford to cut anymore.

Over the next year, we hope to change our state constitution so that we can pass a budget with a majority vote. But, right now, Proposition 63 mental health money, which is supposed to be protected, is threatened because, in the desperate need for resources, folks are trying to take it. Hopefully, they won't be able to access it because one of the things put into Proposition 63 is that you cannot borrow the money. You have to go back to the ballot.

When you are thinking about changing policy, I really believe that mobilizing and organizing people is what truly makes the biggest difference. The evidence and the research are very important, but you do have to hold people's feet to the fire. I believe the way change takes place is through movements. And this is certainly a movement here, a movement for mental health.

RESPONDENTS

Moderator, Cynthia Wainscott

Member, SAMHSA National Advisory Council; Past Chair, Mental Health America

James Wotring

Director, National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development

Systemic Alignment

We have been discussing the children's mental health system. Unfortunately, we have four or five systems that provide children's mental health services. Education is a huge provider. Then, we have the public mental health services and the private sector—Blue Cross/Blue Shield, Aetna—that also provide mental health services. When we are talking about children's mental health services, we also have to talk about alignment of these systems. If we are going to have alignment of financing, we have to line up those systems so they are willing to finance things together.

We have learned a lot over the last 25 years with systems of care. We have learned a lot about better practices for children's mental health. Unfortunately, it takes 20 years now for us to get a good practice from science to service. We can speed that up, do better work than that. We can do it if we think about aligning our systems and aligning our finances around those systems.

Financial Alignment

Looking at the title of Marian Wright Edelman's book, "The Sea Is So Wide and My Boat Is So Small," I was thinking about interacting with Medicaid. I feel like a little person in a little boat within a sea of rules and regulations. Those rules and regulations can blow my boat this way or that, depending on how you want to interpret them.

Rules and regulations affect a lot. We have to write a waiver in Medicaid in order to provide individualized care for a child in a family. To do respite or family support services, we have to write waivers. That does not make any sense. Why couldn't we write a service definition that would allow us to provide those services that children and families need, as opposed to having the right waivers to do the right thing? Let's do the right thing the first time.

We have an opportunity with Medicaid and the workforce. Graduate medical education is paid for with Medicaid. We support a ton of physicians who are trained using Medicaid money. We could use that same process to support graduate education of psychologists and social workers, the ones who actually provide most of the mental health services for children. Think about ways we could use the vehicle that is already there, that states and the federal government and universities could partner around to provide these services.

Quality and Accountability

We are not aligned around quality and accountability, either. We have ways now to measure children's and families' functioning. Are they improving or not improving? What do we do differently in the way of services that we provide? If they are improving, that is great. Let's get them into the community, keep them in the community, and support them in the community. But, if they are not improving, let's try something different. We have data now and ways to help us think better about how we provide services to children and families. Evidence-based practice is the right thing to do and you can tell that by the data. When it is not the right thing to do, we can do wraparound or other individualized care for that child and family.

We still spend way too much money on inpatient and outpatient services. Families are telling us they want more support in the community. It is one thing for us to be institutionalized and put more children in the community. But we have to put them there with the supports they need, such as respites for the family and individualized behavioral supports for that child in the school. We cannot just put

them in the community with one hour a week of outpatient psychotherapy. It is not fair to the families.

We also have new and innovative ways of providing evidence-based practices all across the country. In some cases, this requires bundling certain services, like therapy and case management. Multisystemic therapy (MST), an evidence-based practice, is an example of bundling therapy with case management. But, again, Medicaid is not working with states to align itself so that MST can be bundled and provided in all states.

In addition, Medicaid does not allow the use of mental health diagnostic codes appropriate for children ages 0 to 3. States have to use the

Diagnostic and Statistical Manual (DSM-IV) instead of more appropriate codes like the diagnostic coding (DC: 0–3R).

Medicaid operates within a sea of rules and regulations that need to be aligned on a national and state level with best practices and evidence-based practices. We know it takes 15 to 20 years for a practice that has been proven to work scientifically to move from the research to the field. One of the impediments is the way we reimburse these services with Medicaid. Simply aligning best practices and evidence-based practices with the way we reimburse for these services through Medicaid could improve this situation without having to change a rule or law and, in fact, could help save the taxpayer money.

Mark Trail, M.Ed.

Former Chief, Medical Assistance Plans, Georgia Department of Community Health

As a former Medicaid director, part of my function today is to help you gain perspective. When trying to get the next thing done in your own environment, your own state, it is important that you understand the person with whom you are talking. Speaker Bass suggested that the way to make change in policy is to organize and apply public pressure. I would add one word that I think that is key: persistence.

Do not leave your research and best practices behind. Most public officials do not have an epiphany from this great information that you have brought them because there are so many other things that influence what they do and how they have to do it. But, it is still important to have good science behind what you do because, if you do not, it will be very easy to get shot right out of the saddle. You have all heard the joke, an anecdote is certainly something to respond to but two anecdotes make public policy.

The rules that relate to Medicaid, certainly the Social Security Act Title XIX, were written over 40 years ago. Most of our health insurance plans are quite different from what they were then. Because it is written in code, it is very hard to change. In fact, what I would call nominal changes have been made to Title XIX over the past 40 years. The addition of Early Periodic

Screening, Diagnosis and Treatment (EPSDT) greatly affected the care that children have available to them, and very recently there were some changes made to the Balanced Budget Act 2005. Besides that, there has not been a lot of change, so we are all frustrated with whether the Medicaid system is designed properly.

Many of you are aware of the very hard position that the Centers for Medicare and Medicaid Services (CMS) has taken over the past couple of years with regards to bundling. I think Georgia was one of the early states, if not one of the first, to get hit with an audit around what we use to call our “therapeutic residential intervention services” where, basically, we paid a per diem. We did have it tiered according to acuity levels. Basically, it was a bundled or per diem payment to provide services, counseling, and so forth.

I do think that there will be some opportunity for discussion about the way the current administration has very literally interpreted the regulations as written in Title XIX 40 years ago and some of the associated code of regulations. But they have taken a very literal interpretation of the law and the code of regulations. As a result, the opportunity to have emerging technologies is a struggle at best.

Now, that does not mean it cannot be done. In some circumstances, we consider their concern and approach to our per diem payments to residential services as an opportunity. What happened here in Georgia is that some of the kids got into those services and they would never get out, particularly kids in the custodial care of our Family and Children Services Department. Because Medicaid was paying for that care, it was easy to leave them there and, frankly, probably easy to forget. That is what happens when they turn 18. If somebody actually did do a tracking, they would probably find that the young folks who came out of it, more often than not, continued to be in trouble or have trouble, whether on the mental health side or the correctional side.

This is an example of how we have used a case mixed payment system in a nursing home environment. There is a standardized set of data that can be used to evaluate acuity, the MDS or minimum data sets, already available. We were able to use that data and pay nursing homes. Instead of an average cost per year, we were able to pay those who served more acutely ill individuals at a higher rate. We paid a lower rate to those who served folks who were just filling a bed.

The result has been as follows and it has been profound. An independent study done of the acuity levels compared in our own community-based service systems to our nursing home environment, and this was after several years of a case mixed payment system, an independent entity that has MBS data from folks all over the country said Georgia had achieved something that many states never did achieve. And that was, if you look at the acuity level as a bell-shaped curve, for those in the nursing home and those in community, in most states that curve looks the same.

Through the case mixed payment system, we began to separate those curves. That bell-shaped curve was much stronger on the more acutely ill side for those in institutional care and in home community-based care. While there was still some convergence of the curves, for the most part in the home community-based service system, the folks who were less acutely ill were being served in the home community-based setting, which was not the case at the beginning of that effort. I think it does underscore that this may be something valid and appropriate to take a look at.

Discussion

C. Wainscott: How do we incentivize the movement toward adoption of new knowledge?

J. Wotring: I think we have to find ways to pay the additional cost. There are ways to cost that in Medicaid for the training and the infrastructure that needs to be developed around any new practice, whether it is a good program or an evidence-based practice. Uptake of those practices have to be supported and it has to require funding. It could be Medicaid or it could be other funding sources.

But the uptake of new services is not as quick and as easy as we think. You have to create an environment for that worker to be able to be willing and wanting to learn something new. So, it is the supervisor, and then the organization has to support that supervisor. The system has to support that organization for the uptake of these things to go a lot quicker than it does, and we do not have that height of support of systems at this time. We are learning a lot, but we still have a long way to go before our systems and organizations are ready for the quick uptake of new and better science.

C. Wainscott: Mark, probably better than anybody I know, you understand what it costs people when the mental health system and Medicaid system are as unconnected as they are.

We also have to develop some righteous indignation that our mental health system is isolated from the rest of the health systems and from the community.

and go to the hospital another agency pays for it. How do we go about getting a more rational incentive?

M. Trail: A state can think about a couple of things. It is a fact that, of medicines that have equal clinical value, one may cost a lot more

than the other. The payer thinks it is reasonable to consider whether the less costly one is more appropriate to use than the more costly one, all clinical benefits being equal. However, it is also important for any payer to make certain that an appropriate clinical job has been done to determine what those relative benefits are, whether they are real or not, and what the special circumstances are.

With regard to medication choice, the other important thing is that the more opportunity you have to put the delivery of a health benefit together, the less opportunity you will have for these misaligned incentives to toss the person over the fence. Georgia has done that to a degree, not with the medication benefit but with all the rest of the rehabilitation option benefit that is allocated to our state mental health authority. New Mexico has received a lot of attention for its braided funding approach.

Making sure you can, to your best ability, align incentives so that the total health of the individual is not the responsibility of a single payer has a tremendous benefit.

R. Frank: You can easily go down the path of trying to micromanage clinical care once we start this conversation. At the end of the day, we have to recognize that providers are extraordinarily skilled. They see much more than any payment system or regulatory system could ever see. I think we have to rely on trusting them but try to create an environment where they do not have an excuse to provide anything but the best stuff.

That means making sure that the money does not get in the way, making sure that they are measured, and that they cannot pretend they are doing evidence-based treatment if they are not. We have to be respectful, set up systems where we trust the provider, and do things that support and promote them doing their best.

K. Bass: Persistence. I think that is absolutely right in terms of changing public policy. Many

Discussion

of you have been successful in changing public policy only to find, a few years later, that policy reversed or altered. Our new president is going to have to face and undo a lot of the damage that has been done over the last eight years. We should also be very creative in how we use the media because one of the best ways to pressure elected officials to bring about public policy change is through the strategic use of the media.

C. Wainscott: The Unclaimed Children Revisited report is a big door that we need to figure out how to walk through. Another huge thing before us is the passage of parity. I have heard Mrs. Carter say a number of times, when insurance companies pay for mental illnesses, it then will be alright to have them, and that will help us in our battle against stigma.

When the surgeon general's report on mental health came out, The Carter Center convened pollsters, people who sample public opinion, and

asked them how to move key messages forward. One of the key messages was that 20 percent of people will have a mental illness every year. The pollsters came back and said, people do not believe that 20 percent of the people in America will have mental illness every year, but they do believe that one in five would. And that became the message.

Let's develop some righteous indignation. Our mental health systems are set up so that people have to descend into crisis to get into them. That is not rational. But here is the part that I think we do not grasp emotionally: it is not inevitable.

We also have to develop some righteous indignation that our mental health system is isolated from the rest of the health systems and from the community. We have a right to be mad about that, and that can drive our energy.

GENERAL DISCUSSION

Thomas E. Bornemann, Ed.D.

Director, Carter Center Mental Health Program

Janice L. Cooper, Ph.D.

Interim Director, National Center for Children in Poverty

At this year's symposium, participants were divided into six working groups. Each group was given a different charge related to Unclaimed Children Revisited and the current work and need for improvement in the field of children's mental health. The following represent the comments and recommendations that were put forth by each working group.

Charge 1: Leading a Legislative and Public Information Agenda

The findings from Unclaimed Children Revisited provide an opportunity to move the field around a federal and state legislative agenda to advance optimal children's mental health. It also potentially creates momentum to reshape the public discourse on children's mental health. The federal legislative agenda in particular needs to be responsive to increasing capacity and improving quality to meet the needs of children,

youth, and families. This working group recognized the following avenues as potential strategies for action:

The core principles and values that are embraced by Unclaimed Children Revisited should undergird legislation at the federal and state levels. This is necessary to ensure that the provision and quality of children's mental health services are further advanced and sustained in the near future.

It is imperative to move toward a new agenda and develop the political will to change the children's mental health system. That can be done through taking advantage of legislative opportunities like State Child Health Insurance Program (SCHIP), parity, Medicaid, health care reform, SAMHSA reauthorization, the Healthy Transitions Act, No Child Left Behind Act, Education Begins at Home Act, Mental Health and Schools Act, Child Health Care Crisis Relief Act, and others. Any new legislative provisions pertaining to mental illnesses should be

accountable, responsible, and sensitive toward children who have mental health problems.

Such legislation should address the financing and alignment of resources used in the provision of care. We recommend exploring the potential of using financial incentives, such as loan forgiveness, to encourage providers to go into children's mental health. An element of accountability should be incorporated in such reforms. Providers should be held accountable to stakeholders for the reimbursements they receive.



Any financial reforms will not be successful unless they act responsibly toward consumers. Requiring mental health and substance use competencies by providers caring for children within the HRSA training grants is a potential guarantee for a responsible approach toward consumers.

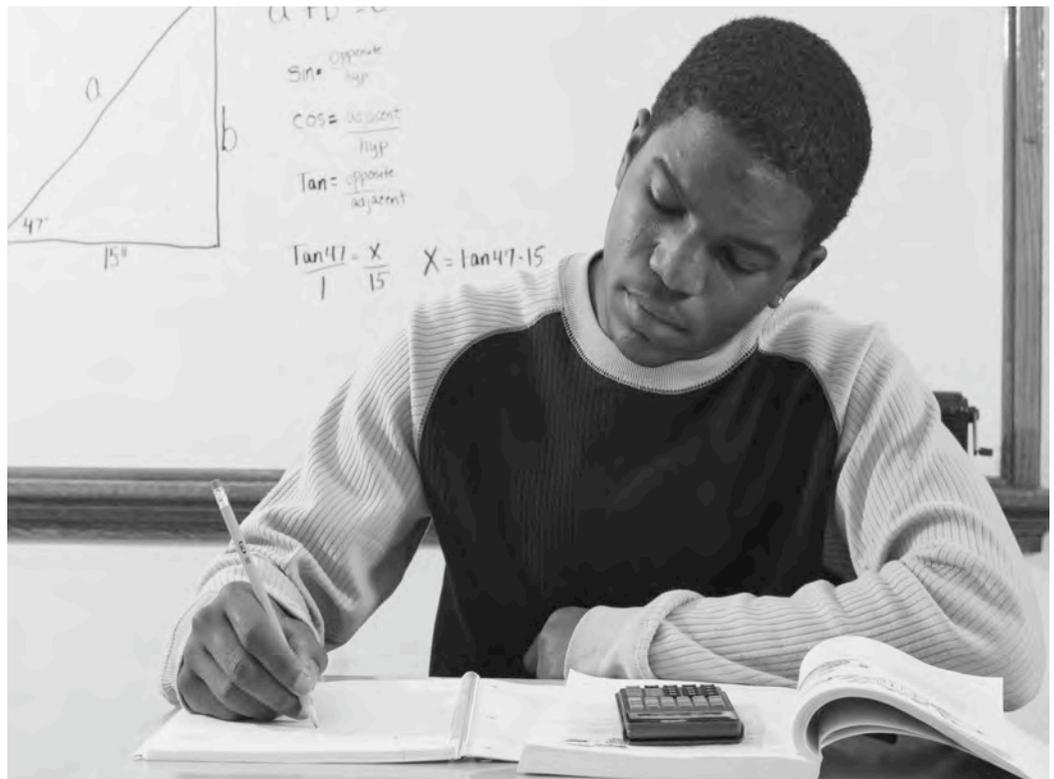
Children and youth with mental health problems are unique and require care that is sensitive to their needs. SAMHSA, HRSA, and the Indian Health Service should take into account cultural sensitivity in addressing delivery of health care to children with mental health problems.

Those ambitious legislative strategies cannot be achieved without broad-based consensus building among various stakeholders. They should involve working across a broad array of programs, agencies, and organizations, including HHS, education, juvenile justice, transportation, homeless groups, and others. A successful collaborative effort requires evidence-based practices and policies. Therefore, it is imperative to establish a consistent infrastructure linked to universities.

An advocacy campaign should be conducted targeting both the public and policy-makers with various messages aimed at the same goals and objectives. The common theme, however, should be a social marketing campaign. Disseminating Unclaimed Children Revisited will help to achieve this goal. In addition, Web-based training should be conducted to chart children's mental health and substance abuse. It could prove useful to use Children's Mental Health Awareness Day each May to launch such a campaign. It is necessary to include lessons learned from previous reform initiatives in public-relations campaigns.

The advocacy campaign should take into account those lessons to enrich the national health reform attempts.

How can we join efforts to embed mental health strategies into broader public health reform and community development initiatives? Mental health care reforms should be an integral part of national health reform initiatives. Health reforms will be incomplete without equal attention to mental health priorities. That would include, but is not limited to, the incorporation of mental health and substance abuse issues in the concept of the medical home model. At the state level, it is imperative to develop and implement coordination programs for children's mental health and substance abuse issues. This necessitates a parallel coordinated mental health and substance abuse program at the federal level with the inclusion of adults as well. It is imperative to include schools in the healthy emotional development of students. These strategies, often called whole-school initiatives, such as positive behavioral interventions and supports, should involve families in the healthy mental and emotional growth and development of their children.



Charge 2: Business and Philanthropy

What is and should be the role of business and philanthropy in improving children's and families' access to mental health services? The health care field responds in large measure to business as employers, payers, and investors. Major reforms in health care policy have been propelled by business, including new innovations focused on outcomes and quality such as pay-for-performance. However, there has been very little leadership from business in advancing children's mental health. Further, in recent years, the influence of foundations and the number of foundations willing to invest in child mental health policy work has declined. It is important to tap into the priorities of the business and philanthropy communities and help shape those priorities around investing in the well-being of children. The group identified how this may be executed in both the business and philanthropy communities:

To demonstrate the importance of health and well-being in the workplace, we need to use outcome data to show how productivity and cost are affected by poor health among employees and their families, and how health can be improved. Once a business becomes engaged in health improvement, we must assist in supporting them.

The group discussed creating an affinity group of foundations that would have interest in funding children's mental health. The foundation group would fund efforts to reframe how nonprofits and the corporate world approach children's and family mental health and well-being in the business context. This group would also fund the retooling of nonprofit and corporate wellness programs.

This group could address government involvement by using foundation money to leverage government dollars or by funding areas that government organizations cannot.

Media are a valuable resource that must be used to promote children's mental health.

Charge 3: Developing a New Research Agenda

Adoption of effective research-informed children's mental health practices is not widespread. Working group 3 was asked to address the gaps between research in the field of children's

mental health and practices currently in use that are associated with good outcomes on the ground but lack empirical validation and a research base. The group was asked to address three questions relating to research in the field and how it may or may not be implemented in practice. What impediments to research and dissemination are really critical? What are the priorities and gaps when it comes to research?

At this point, we know far more about systems, intervention, and services at the micro and individual levels than we do at the macro and community levels. We have been successful in addressing pieces of intervention, such as treating depression and anxiety, but we have yet to take a holistic approach to intervention.

While we are able to identify how to increase resiliency among children, we need to transfer these concepts into community settings.

For a child to excel in his or her environment, there are several things that are needed, including safe and affordable housing, effective school systems, and strong social fabric. It is our responsibility to better understand how to achieve these things so that all children can live full and productive lives. Similarly, we need to measure these environments within a racial and cultural context.

We still need to know more about how we measure and consider healthy communities within a racial and cultural context. We have not necessarily looked at how they can be integrated in the mental health and public health fields.

We need to understand what incentives work for system change. What is it really going to take to get a community interested in moving toward a public health framework?

We need to understand how to involve youth and families in research. We don't necessarily know how to make children's mental health a national priority through social marketing and promotion.

We need to develop an inventory of what we already know from research to better understand how to reduce and overcome stigma.

We need to begin and end our research in natural settings, places like schools and communities.

There are competing priorities when it comes to research. This can be an impediment. States may have one set of priorities, academic centers may have another, and funders may have yet another. It is our job to understand how these different priorities really impact our ability to do research effectively.

As we move into a public health context, it is important to focus on using the appropriate language for the context. A critical part is focusing on changing behavior. It is important to either look at how it is being done in other systems or to do independent research to better understand this change in the context of adults.

The following is a 16-point priority list for research:

- Fund a large system of care implementation studies and multisite studies.
- Support basic surveillance.
- Conduct research on mental health conditions and the children affected so we understand the extent of the problem, needs, and outcomes necessary for success.
- Undertake research to better match children's needs with the right intensity of interventions to reduce burden and maximize existing resources.
- Conduct research at the community and neighborhood level to assess variables that impact mental health.
- Conduct more research on the long-term impact of homelessness on youth and families.
- Identify communities with children and youth who are doing very well, and better understand what it is in those communities that help children and youth to do well so that we can replicate those kinds of variables in other communities.
- Create systems in communities that monitor outcomes on an ongoing basis as a way to establish community need.
- Conduct more economic and policy research to support the move toward effective interventions in the field.
- Understand how to get those entrenched in the delivery system to do things differently.
- Conduct more research on resiliency that can be applied by families and communities. Publicly funded programs should have a dedicated 5 percent set aside for independent evaluation to help ensure accountability in the service delivered.
- Embed research into real-world strategies.
- Research building capacity and assessing readiness to bring intervention into schools and primary care.
- Put public health into the department of education and school professionals into public health for cross-pollination at federal, state, and local levels.
- Research mechanisms for moving from promising practices to evidence-based practices in a timely manner.
- Build evidence to show that having families involved in services leads to better outcomes.

Charge 4: Developing Fiscal Policies That Work

More than 20 years after Jane Knitzer pointed to the funding imbalance between institutional and community-based mental health for children and youth, and despite current investments in mental health services and supports, only a fraction of the children and youth with mental health needs and their families access services; even fewer access appropriate, effective services and supports. Constraints on how current resources are expended add to the challenge of how to align fiscal policies with effective strategies.

The group reviewed areas of prevention, early intervention, and treatment in the context of the imbalance between institutional and community-based care. Considering both the private and public settings, the group recognized the need for policies that are grounded in the principles of quality, equality and accountability.

The group identified the need for developing financing strategies that move parallel with the shift toward preventive public health measures. A major pillar of this strategic financial policy would be identifying and maintaining dedicated funding resources for prevention and health promotion.



In addition, securing fixed percentages of different funds toward prevention could prove an effective fiscal policy considering the current economic crisis.

The imbalance between community-based and institutional care can be readdressed through explicit policies that aim at developing fiscal incentives at local levels. This would be facilitated by the presence of a coordinated or a naturally managed environment that is close to the communities themselves so that decision making can occur in balance with those financial decisions. For example, fiscal policies should reflect the state of knowledge regarding effective services and supports.

Fiscal barriers exist to a children's mental health policy grounded in accountability, quality, service capacity improvements, and a public health framework. One of those barriers includes the inability to bundle outcomes with financial incentives. This requires introducing payment

systems that incentivize providers to offer services that meet outcome standards. Such a policy reform will improve the prospects of not only accountability in the system but also better quality and capacity. It is imperative to conduct an analysis of the Medicaid waivers program over the past 10 years. It is equally important to promote equality in the provision of services as part of the Medicaid program.

It is necessary to ensure that both private and public health insurance plans pay for effective mental health interventions and support strategies. Those strategies should appropriately reflect the age of the consumers. To achieve that goal, marketing strategies may be used to reach out to regulators, payers, and insurers. Conversations with those different stakeholders will introduce a common understanding of mental health. Parity and parity implementation provide a very good opportunity to begin conversations about mental health and the benefits to mental health.

Charge 5: Implementing What Works in Prevention and Treatment

A wide variety of evidence-based practices (EBPs) and promising programs have been developed that can apply to children and youth with mental health problems and their families, yet few are adopted. Even fewer are being properly and consistently implemented. Implementation of effective evidence-based prevention and treatment strategies remains difficult in public mental health systems. Evidence of the adoption of those strategies in private practice settings is scarce. Further, a significant backlash around implementation of effective practices has emerged that focuses on appropriate care settings, cultural and linguistic relevance, provider acceptance, and readiness.

What are the barriers to both adopting and implementing EBPs? One of the barriers for the implementation of effective prevention and treatment strategies is the confusion around a host of terms like prevention, evidence-based practice, and practice-based evidence. The two latter terms should be understood clearly; evidence-based practices are those that are proved through rigorous research to be effective. Practice-based evidence, on the other hand, is

when the practice environment informs the research. Furthermore, they incorporate a range of factors such as compassion, trust, and respect in an overly professional and technical field of research.

The fragmentation of the health care system in general and primary health care in particular is a significant barrier to implementing effective mental health prevention and treatment strategies. This macro-level structural dilemma is further complicated by a micro-level expanding gap between providers and consumers. The failure to involve patients, their families, friends, and communities in interventions will lead to grave consequences for the effectiveness of those interventions.

The above barriers can be addressed through a variety of strategies. It is important to identify potential publication sources that can be used to publish research and get the word out. It is imperative to identify through business technology models the structural characteristic of mental health services that need to be addressed, ranging from service delivery to marketing. Diversity should be taken into consideration when dealing with those issues. This would prove very useful for the implementation of relevant intervention that answers the practical needs of the community. Learn from the community rather than blindly depending on knowledge concluded from academic assumptions. Such an approach requires consensus and congruence among consumers, providers, and researchers. Attention to diversity does mean that it is imperative to introduce models that are strategically aligned at the local, state, and federal levels. This could carry the potential for greater impact.

There should be a paradigm shift in the provision of care to people with mental illnesses. It is imperative to involve both individuals and their communities in interventions aimed at their management. This notion needs to be applied to all the administrative, legislative, research, academic, and provision aspects of mental health care services. It is not enough to conclude facts and approaches about mental health issues without involving consumers and their families and explore their worldview in the process.

However, this goal cannot be achieved without empowering and energizing consumers and their communities to enable them to be equal partners in the recovery process.

Charge 6: Integrating Mental Health Across the Developmental Lifespan in Non-Mental Health Settings

The findings of Unclaimed Children Revisited reinforce that while most mental health services for children and adolescents are delivered in primary care settings, policies that govern mental health financing and service delivery ignore a public health framework as a vehicle for expanding capacity and enhancing quality. In particular, settings such as schools, early childhood environments, and primary care practices could form the foundation for increasing access and quality. Instead, fragmented and parallel systems of care exist. Little attention is paid to the developmentally appropriate application of interventions across these settings. This group was charged with developing strategies for addressing issues in non-mental health settings with non-mental health providers.

This working group identified a broad range of potential non-mental health settings, from schools to playgrounds, and provided the following recommendations:

- Conduct community mapping to identify places where people gather within neighborhoods and communities, in thinking about possible places to promote mental health.
- Review best practices to craft strategies for developing innovations in non-mental health settings.
- Make the training curriculum and tools used by other states or regions available to all.
- Incorporate strategies across the lifespan. The use of parent peers, particularly for transition ages, could be a beneficial resource for parents.
- To promote health and wellness, Girl Scouts and Boy Scouts could offer merit badges for both.



- Present a presidential commendation program for wellness that includes a mental health component.
- Provide Web-based tools for families, including the use of virtual environments and online communities.
- Use senior centers and places where grandparents could be engaged in thinking about health and wellness for children and youth.
- Develop a fun run for children and youth.
- Use the media in innovative ways to promote the health and wellness agenda.
- Give non-mental health providers basic skills to begin to deal with these issues.
- Align the incentives so that people, even in these non-mental health settings, would be supported in developing new skills.
- Use traditional training venues for teachers, nurses—particularly public health nurses—and recreation workers to educate on mental health and wellness.

Mark S. Atkins, Ph.D.

Dr. Mark Atkins is a professor of psychology and psychiatry at the University of Illinois at Chicago and the Institute for Juvenile Research. He has a long-standing interest in the development of effective mental health services for children and families living in high-poverty urban communities. He is an active researcher in the areas of childhood ADHD and aggression, and on the development of innovative models for community mental health services for children and families. He has written more than 75 papers and chapters and more than 100 conference presentations. He is a consultant to the Illinois Division of Mental Health on a statewide initiative to advance evidence-based mental health practices, leading a series of workshops on behavioral parent training for community mental health staff. He is an active mentor of early career researchers, serving as a primary mentor on five National Institute of Mental Health career development awards and as a mentor for the Institute for Education Science/American Psychological Association (APA) postdoctoral fellowship and the APA Division 53 Society for Child and Adolescent Clinical Psychology.

The Honorable Karen Bass

Karen Bass has been a state assembly member representing Los Angeles' 47th Assembly District since 2005. In May 2008, she made history when the Los Angeles Democrat became the 67th speaker of the California State Assembly, catapulting a Democratic woman to the post for the first time in the state's history. Bass has been a part of the leadership since her first term when she was appointed majority whip and majority floor leader. Before Bass began her political career, she founded and ran Community Coalition, where, as executive director, she built a community-based social justice organization in South Los Angeles to empower residents to get involved in making a difference. Today, the organization is considered a model for community engagement throughout the country. She graduated from California State University, Dominguez Hills (B.A., health sciences) and University of Southern California School of Medicine (physician assistant certificate).

William R. Beardslee, M.D.

William R. Beardslee is academic chairman of the Department of Psychiatry at Children's Hospital in Boston and the Gardner Monks Professor of Child Psychiatry at Harvard Medical School. He received his Bachelor of Arts degree from Haverford College and his medical degree from Case Western Reserve University. He trained in general psychiatry at Massachusetts General Hospital and in child psychiatry and psychiatric research at Children's Hospital in Boston and has a long-standing research interest in the development of children at risk due to parental severe mental illness. He is especially interested in the protective effects of self-understanding in enabling young people and adults to cope with adversity and has studied self-understanding in civil-rights workers, survivors of cancer, and children of parents with affective disorders.

Janice Charles

Janice Charles is executive director of North Country Children's Clinic, a not-for-profit agency that she helped build with her late husband in 1971. Children's Clinic provides community and school-based medical, mental health, dental, nutrition, and advocacy services for uninsured children and families across four counties in northern New York state. Charles has a Bachelor of Science in nursing from Hartwick College in Oneonta, N.Y. She has been active with several organizations at both the state and local levels, including the Governor's Advisory Board to the Children's Cabinet, the Fort Drum Regional Health Planning Organization, and several New York state organizations: Rural Health Council, Assembly Perinatal Advisory Committee, Senate Health Care Forum, and Association for Rural Health. She was honored in 1991 by the New York state legislature as the Central New York Nurse of Distinction. In 1993 she received the ATHENA Award for outstanding women in business; in 2002 she received the Harriet Tubman Humanitarian Achievement Award.

Janice L. Cooper, Ph.D., M.P.A.

Dr. Janice L. Cooper is a health services researcher who specializes in children's mental health. Her research has focused on quality of care for children and youth and includes work on attention-deficit/hyperactivity disorder (ADHD), cultural and linguistic competence, and mental health financing. Since 2005 she has led the work of Unclaimed Children Revisited, a series of policy and impact analyses of mental health services and supports for children, youth, and their families. She also directs the National Center for Children in Poverty's new adolescent health initiative and Project THRIVE, an early childhood initiative. She holds an appointment in the Department of Health Policy and Management at the Mailman School of Public Health, where she teaches a graduate course in child health policy. She holds undergraduate and graduate degrees from University of Essex in England, Columbia University, and Harvard University.

Carmen Diaz

A parent and relative caregiver of children with severe emotional disabilities (SED), Carmen Diaz began volunteering with the Department of Mental Health in 1995, advocating, supporting, partnering, and empowering parents who also have children with SED. She became employed by the department in 1996. She is now a countywide parent advocate, overseeing training and policy. She is very involved with policy issues at all levels of government, from local to national. Diaz is president of the board for United Advocates for Children and Families and also serves as secretary on the board of Parents of Los Angeles Network, a newly formed parent organization. In 2005, she was appointed by the governor of California to the Mental Health Services Act Oversight and Accountability Commission; she finished her term in 2007.

Marian Wright Edelman

Marian Wright Edelman, founder and president of the Children's Defense Fund (CDF), has been an advocate for disadvantaged Americans her entire professional life. Under her leadership, the Washington-based CDF has become the nation's strongest voice for children and families. She began her career in the mid-'60s when, as the first black woman admitted to the Mississippi Bar, she directed the NAACP Legal Defense and Educational Fund office in Jackson, Miss. In 1968, she moved to Washington, D.C., as counsel for the Poor People's March. Edelman founded the Washington Research Project, a public interest law firm and parent body of CDF. She has received many honorary degrees and awards, including the Albert Schweitzer Humanitarian Prize, the Heinz Award, and a MacArthur Foundation Prize Fellowship. In 2000 she received the Presidential Medal of Freedom, the nation's highest civilian award, and the Robert F. Kennedy Lifetime Achievement Award for her writings. A graduate of Spelman College, Edelman holds a law degree from Yale University.

Richard G. Frank, Ph.D.

Richard G. Frank is the Margaret T. Morris Professor of Health Economics in the Department of Health Care Policy at Harvard Medical School. He is also a research associate with the National Bureau of Economic Research. Frank served on the Congressional Citizens' Health Care Working Group. He advises several state mental health and substance abuse agencies on issues related to managed care and financing of care. In 1997 he was elected to the Institute of Medicine. Frank was awarded the Georgescu-Roegen Prize from the Southern Economic Association for his collaborative work on drug pricing, the Carl A. Taube Award from the American Public Health Association for outstanding contributions to mental health services and economics research, and the Emily Mumford Medal from Columbia University's Department of Psychiatry. Frank received the John Eisberg Mentorship Award under the Institutes for Health National Research Service Awards.

Robert Friedman, Ph.D.

Dr. Robert Friedman is currently a professor in the Department of Child and Family Studies of the Louis de la Parte Florida Mental Health Institute (FMHI), University of South Florida. From 1984 through 2006, Friedman was a department chair at FMHI, and in 2006–2007 he served as interim dean. Since 1984 he has been principal investigator of one of two federally funded research and training centers in children's mental health, and has engaged in research on the prevalence of mental disorders, the development of systems of care, and the effectiveness of various system change strategies. Friedman has served as chair of the Transformation Work Group of the Child, Adolescent, and Family Branch of the Center for Mental Health Services, and in that capacity prepared a report on family choice of services and providers in children's mental health. Friedman also has served on the Child and Family Subcommittee of the President's New Freedom Commission on Mental Health, the Planning Board for the Surgeon General's Report on Mental Health, and has been a consultant to over 40 states on children's mental health.

Rosa Gil, D.S.W.

Dr. Rosa M. Gil is founder, president, and CEO of Comunilife, Inc., a multiservice, not-for-profit organization, founded in 1989, that assists New Yorkers in need, including people living with HIV/AIDS and mental illness. Gil served as health policy adviser to the mayor and health administrator of New York City. Some of her accomplishments include prevention and wellness initiatives, expansion of primary care, quality improvement of health care in the New York City public hospital system, expansion of housing and case management for people living with HIV/AIDS and mental illness, increased access to health insurance, suicide prevention among Latina adolescents, and development of the Multicultural Relational Approach for Diverse Populations. Gil serves on the Commission of Health Care Facilities in the 21st Century and Mayor Michael R. Bloomberg's Commission on Women's Issues. She is one of the founders of the Urban Institute for Behavioral Health of New York City, Latino Commission on AIDS, the Association of Hispanic Mental Health Professionals, and 100 Hispanic Women.

Renata J. Henry, M.Ed.

Renata J. Henry is currently deputy secretary for behavioral health and disabilities in the Maryland Department of Health and Mental Hygiene. She was previously the director of Division of Substance Abuse and Mental Health, an operating division of Delaware Health and Social Services, where she was responsible for the administrative direction and oversight of public-sector behavioral health services for adults in Delaware. She is a member of the Substance Abuse and Mental Health Services Administration (SAMHSA) Advisory Committee for Women's Services and has participated on numerous committees, expert panels, and task forces that have advised SAMHSA on behavioral health policy, practice, financing, and cultural competence issues. Henry holds a bachelor's degree in social work from the University of Wisconsin and a master's degree in education from Antioch University.

Larke N. Huang, Ph.D.

Larke Nahme Huang, a licensed clinical-community psychologist, was appointed senior adviser on children, Office of the Administrator, in the Substance Abuse and Mental Health Services Administration (SAMHSA) at the U.S. Department of Health and Human Services in April 2006. She is also the agency lead on cultural competence and disparities elimination. For 25 years Huang has worked at the interface of practice, research, and policy. She has been a community mental health practitioner, a faculty member at the University of California-Berkeley and Georgetown University, and a research director at the American Institutes for Research. She has worked with states and communities to build systems of care for children with serious emotional and behavioral disorders.

Jane Knitzer, Ed.D.

Note: Jane Knitzer died in March 2009. Dr. Jane Knitzer was executive director of the National Center for Children in Poverty (NCCP), whose mission is to promote research-informed policy to improve the lives of low-income children and families. She was also a clinical professor of population and family health at the Mailman School of Public Health at Columbia University. As a psychologist, Knitzer focused her own research on improving public policies related to children's mental health, child welfare, and early childhood. Her work on mental health includes the groundbreaking policy report, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, and the report *At the Schoolhouse Door: An Examination of Programs and Policies for Children with Behavioral and Emotional Problems*. Most recently, Knitzer was a leader in calling attention to the importance of addressing social and emotional issues in young children.

Danielle Laraque, M.D.

Danielle Laraque is chief of the Division of General Pediatrics at the Mount Sinai School of Medicine, Department of Pediatrics (2000–present). Laraque completed her medical studies at the University of California at Los Angeles. She is the president-elect of the Academic Pediatric Association, the leading pediatric generalist academic association in the United States. She is also the American Academy of Pediatrics (AAP) District II vice chair (2004–2010). She was appointed to the AAP National Mental Health Task Force (2005–present) and chairs its Decision Support Committee. She was a member of the Maternal and Child Health Bureau, Bright Futures National Health Promotion Work Group (1998–2004) and the national AAP Bright Futures Project Advisory Committee (2004–2007). She was the 2001 United States Public Health Service Primary Care Policy Fellow, and is a member of the National Institute of Mental Health Standing Committee on Interventions for Disorders Involving Children and Their Families.

Deborah F. Perry, Ph.D.

Deborah Perry joined the faculty of the Johns Hopkins Bloomberg School of Public Health (JHSPH) in the Department of Population, Family, and Reproductive Health in September 2006. Perry's research focuses on community-based participatory approaches to designing and testing preventive interventions for young children and their caregivers. At JHSPH, she is a co-investigator on the National Children's Study and involved in a variety of research projects on early childhood health and development. Prior to her appointment at JHSPH, she served on the faculty of the Georgetown University Center for Child and Human Development for nearly a decade; during the latter part of her tenure there, she served as the director of research. She has also served as evaluator of several models of early childhood mental health consultation services in child care settings in Maryland and a community-based violence prevention initiative in the North Capitol area of Washington, D.C. She has written numerous peer-reviewed articles and translational publications, and has given more than 50 national trainings, presentations, and lectures on a wide variety of maternal and child health topics. At JHSPH, Perry is the lead instructor for the course on early childhood health and development.

Mary Jane Rotheram-Borus, Ph.D.

Dr. Mary Jane Rotheram-Borus has spent the past 20 years developing, evaluating, and disseminating evidence-based interventions for children and families. She has worked extensively with adolescents, especially those at risk for substance abuse, HIV, homelessness, depression, suicide, and long-term unemployment. Rotheram-Borus has directed and implemented several landmark intervention studies that have demonstrated the benefits of providing behavior change programs and support to families in risky situations. She has received more than 40 grants from the National Institute of Mental Health and the National Institute on Drug Abuse to design prevention programs for children and families at high risk for HIV, mental health problems, suicide, and substance abuse. In 2001, *Science* magazine ranked her as number two in their list of top-funded National Institutes of Health multigrant recipients; she was the only woman in the top 10.

Dalia S. Smith

Dalia S. Smith is a family advocate for the Association for Children's Mental Health (ACMH) in Saginaw, Mich. Through the partnership of Saginaw County Community Mental Health Authority and ACMH, Smith provides services to families of children with serious emotional disturbances. Smith is a member of the Saginaw County Human Services Collaborative Body, the Saginaw County Great Start Collaborative and Parent Coalition, and the Saginaw County Intermediate School District Parent Advisory Committee. She participates in the Saginaw County Department of Human Services Family to Family Initiative as a community representative who sits in on team decision-making meetings. Smith is a graduate of the University of Michigan in Ann Arbor.

Sue L. Smith, Ed.D.

Sue Smith is a founding member of the Georgia Parent Support Network and has been recognized for her work as the recipient of the 1995 Tipper Gore Remember the Children Award, 1994 Mental Health Association of Georgia Child Advocate Award, and 1996 Rosalynn Carter Caregiver Award. Smith is past president of the Federation of Families for Children's Mental Health Association of Georgia and past chair of the Mental Health Planning Council of Georgia. In addition, Sue has consulted with the Georgia Department of Human Resources, Macro International, Georgetown University, and many states as well as several regions in Georgia regarding issues surrounding children with serious emotional disturbance and the delivery of services to these families and children. She obtained her doctorate in management of children and youth programs in February 2000 and has since taught a course at Harvard University.

Sandra Spencer

Sandra Spencer has navigated a highly visible career path through local family organizing, state-level systems of care development, advocacy, national meeting planning for both the Federation of Families for Children's Mental Health and the Technical Assistance Partnership, and providing training and technical assistance to family-run organizations. But, in addition to her professional successes, Spencer's personal struggles have led to the deepest ways of knowing and learning. She has spent sleepless nights protecting her son from the symptoms of his emotional disorder. Spencer's leadership has advanced the family advocacy movement and forged new relationships with national and international organizations such as the Child Welfare League of America and the International Association of Chiefs of Police. Sandra is also the mentor and protégé for the newly emerging national youth organization, Youth M.O.V.E. (Motivating Others Through Voices of Experience) National, a subsidiary of the National Federation of Families for Children's Mental Health.

Patrick H. Tolan, Ph.D.

Patrick H. Tolan is director of the Institute for Juvenile Research at the University of Illinois in Chicago. In this position for the past nine years, he is now guiding the institute as it reaches its centennial year as the first child mental health research and service clinic in the United States. Tolan is also professor in the Department of Psychiatry and College of Public Health at the University of Illinois. For more than 20 years, he has conducted research on a broad set of issues in children's mental health with particular focus on children in urban impoverished communities. He regularly advises multiple federal agencies and offices, state and local governments, and expert panels for the field and has provided testimony for Congress several times. Tolan serves on several boards and advisory groups related to local, national, and international efforts to help advance the state of mental health of children and families. He received a Presidential Citation from the American Psychological Association in 2008, and in 2007 was given the Star of Science Award from the Children's Brain Research Foundation.

Mark Trail, M.Ed.

Mark Trail recently retired as the chief of medical assistance plans in the Department of Community Health for the state of Georgia. As director of the state Medicaid agency, he was responsible for all Medicaid functions and services, as well as Georgia's SCHIP program, PeachCare for Kids. While serving as Medicaid director, Trail implemented a successful conversion from the outpatient clinic option to the rehabilitation option for people with mental illnesses and addictive diseases. Prior to Medicaid, Trail worked in a variety of positions in the mental health, developmental disability, and addictive disease field, successfully reducing reliance on a variety of institutional care settings during his tenure in each position. Trail attended Georgia State University, where he received a master's degree in community counseling.

Cynthia Wainscott

Cynthia Wainscott is a member of the Substance Abuse and Mental Health Services Administration's National Advisory Council. She has been nominated by the president and confirmed by the Senate to serve on the National Council on Disability. She was acting president and CEO of Mental Health America in 2006. Wainscott is a member of the Governor's Mental Health, Mental Retardation, and Substance Abuse Advisory Council, the state Medicaid agency's Drug Utilization Review Board, and is a current member and past chair of the Mental Health Planning and Advisory Council. She serves on the Governance Committee of the Mental Health Services Coalition and on the boards of Georgia Community Trust and Better Health Bartow. Wainscott holds a Bachelor of Arts in communications from Metropolitan State University.

James Wotring, M.S.W.

Jim Wotring is director of the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development. He is former director of Programs for Children with a Serious Emotional Disturbance at the Michigan Department of Community Health. He completed a 1915(c) waiver for children with a serious emotional disturbance that was approved by the Center for Medicaid Services in the fall of 2005. His postgraduate training has been in family therapy, leadership, and consultation, and he has been active in various national groups supporting the development of systems of care for children's mental health. An international and national consultant, Wotring has published in the area of outcome management and using outcome data to support system change and set public policy.

Captain Verrottica Young

Captain Verrottica Young is a 23-year-old former foster youth from California—a sister, transperson, poet, leader, advocate, and new aunt. Young firmly believes in the healing power of advocacy for people who come from oppressed communities and situations and has been a part of social change movements for the past 10 years. Serving as one of the advisers for the National Center for Children in Poverty research project, Young knows well from personal and professional experience the work that is needed in the system.

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