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The Provider System for Children's Mental Health: Workforce Capacity and Effective Treatment

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OVERVIEW — *This issue brief examines two issues that are key to meeting children's unmet needs for mental health care: ensuring that the provider supply is adequate and that the care delivered is effective. It describes the shortage of qualified providers to address children's mental disorders, as well its possible causes; it describes how managed care, to a certain extent, drives practice patterns; and it discusses the gray areas in deciding which providers are most qualified to deliver what care. In addition, this paper introduces what is known about evidence-based care in children's mental health, the extent to which it is being taught and practiced, the extent to which health plans are adopting such practices, and the effect such strategies may have on the makeup of the children's mental health provider field.*

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The Provider System for Children's Mental Health: Workforce Capacity and Effective Treatment

The landmark surgeon general's 1999 report on mental health found that nearly 14 million children—one in five—have a diagnosable mental disorder. Yet most of these children, even those with the most severe impairments, get no care. The report states that there is a shortage of child psychiatrists and of appropriately trained clinical psychologists and social workers to treat children.¹ The President's New Freedom Commission on Mental Health, also found that "the supply of well-trained mental health professionals is inadequate in most areas of the country, [and] rural areas are especially hard hit. In addition, particular shortages exist for mental health providers who serve children, adolescents, and older Americans."²

Provider shortages have been documented in private practice, community clinics, public hospitals, and public mental health care systems that seek to keep severely disturbed children at home with programs such as respite care, day treatment, and therapeutic foster care.

Although the problem of a workforce shortage seems straightforward, the question of how to address the shortage is extremely messy. The mental health workforce is in flux: more disciplines (that is, psychiatrists, psychologists, counselors, etc.) are offering mental health care, their practice boundaries are increasingly blurry to both consumers and health plans, and a number of these professions are in the process of retooling and redefining their roles.

Thus, it is difficult to determine how many more psychiatrists, psychologists, social workers, counselors, and related professionals are needed to boost the supply of children's mental health providers. Increasingly, psychiatrists are getting out of the business of talk therapy and specializing in medication management. Pediatricians, nurse practitioners, and some psychologists are creeping into the domain of psychiatry by prescribing medication to treat children's mental disorders. Clinical social workers and master's degree-level counselors are being paid by health plans to deliver psychotherapy, which is traditionally the domain of psychologists and psychiatrists.

The various disciplines that offer mental health services require different levels of training, offer different areas of expertise, and command different salaries in the health care marketplace. Yet the question of which discipline is best suited to provide medication management and/or psychotherapy

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is by no means clear. Along with questions of how to increase the supply and even out the distribution of children's mental health providers, regardless of their discipline, there are serious concerns about the extent to which the care that professionals are currently offering is effective.

Evidence-based medicine—practices and procedures that have been shown to improve patient outcomes—has become increasingly popular in the past ten years. It is now being applied to mental health. There is a growing body of knowledge that illuminates which medications, and which types of psycho- and behavioral therapies, yield the best outcomes for children with a range of mental disorders. Best practices are even being developed for public systems of care that treat children with serious emotional disturbance. Although evidence-based care for children's mental health is still in its infancy, it is widely acknowledged that much of how providers are being trained, how they practice, and what is being reimbursed by public and private insurers does not match the strategies that have been found to work.

This issue brief examines two issues that are critical in meeting children's unmet needs for mental health care: ensuring that there are enough providers and that the delivered care is effective. The paper describes the nature of provider shortages, discusses how managed care can drive practice patterns, and explores which providers are most qualified to deliver what care. This paper also introduces evidence-based care in children's mental health; the extent to which it is being taught and practiced, as well as which health plans are adopting such practices; and its potential effect on the providers of children's mental health.

WORKFORCE TRENDS

Among all disciplines that provide mental health care to children, there is a striking trend toward the use of professionals who lack specialty training in child mental health. The bulk of psycho- and behavioral therapy is provided by social workers. Most prescriptions for psychotropic medication for children are written by pediatricians and family physicians, not psychiatrists. Experts across the professions generally agree that nonspecialists are not trained appropriately to be providing this type of care. But they do not agree on the extent to which more specialists should be trained, or generalists should retool, to offer children effective mental health care. Undergirding this question of an adequate workforce is the issue of money: the educational costs of becoming trained as a specialist are considerable, health plan payment rates favor lower-paid providers, and comparatively low payment rates are offered to the public sector mental health workforce.

The supply, practice patterns, and overlapping of the various child mental health provider disciplines is described more fully here.

Mental Health Providers Who Prescribe

Children with mental disorders are treated with psychotherapy, behavioral therapy, or medication, and often with some combination thereof. In recent years, the use of psychotropic medication to treat children with mental health problems has increased dramatically. Between 1987 and 1996, psychotropic use among children and adolescents nearly tripled, growing from 1.4 percent to 3.9 percent, or more than 2 million children.³

Children's mental health providers generally fall into one of two categories—those who can prescribe medication (psychiatrists, some psychiatric nurse practitioners, and, increasingly, pediatricians) and those who can conduct psycho- and behavioral therapies (psychologists, social workers, counselors). Child psychiatrists are arguably the only discipline adequately trained to do both, although many complain that psychiatric training programs fall short on preparation for psycho- and behavioral therapy.

This division has its drawbacks. The bulk of the children's mental health workforce has no prescribing privileges, creating demand pressures on child psychiatrists because of the popularity of using medication to treat children's mental disorders. Pediatricians and family physicians, who have less training in prescribing psychiatric drugs for children, are being called on to pick up the slack.

Psychiatrists — Child and adolescent psychiatrists are the providers with the most training in treating children with psychotropic medication. In 1990, the Council on Graduate Medical Education estimated that the nation would need 30,000 child and adolescent psychiatrists to meet the demand in 2000. In 2000, there were 6,300, and no promises of a new flood of trainees. The number of child and adolescent psychiatry residents has remained flat over the past five years.

There is a clear demand for child and adolescent psychiatrists. The federal Bureau of Health Professions projects that just to maintain the current utilization rates of psychiatric care, and considering that currently most children who need care do not get it, by 2020 the nation will need 12,624 child and adolescent psychiatrists but is expected to only have 8,312.⁴

There is both a shortage and a maldistribution of psychiatrists specializing in children. Many rural areas have few if any of these specialists. The ratios of child and adolescent psychiatrists per 100,000 youths vary widely, ranging from 1.3 in West Virginia to 17.5 in Massachusetts.⁵

Two major reasons for the shortage are (a) disincentives in the training programs of child and adolescent psychiatrists and (b) low payment rates from private insurers and Medicaid. Training for child and adult psychiatry is a five-year program (after four years of medical school): three years of adult psychiatry followed by two years of child psychiatry. According to Dr. Tom Anders, president of the American Academy of Child and Adolescent Psychiatry (AACAP), students have little to no exposure

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to child psychiatry in their first three years of training, when they are forming their professional identity. And many cannot afford to accrue an extra two years of debt before starting to practice. "At least half of students who are interested in child psychiatry decide not to go the full route," says Anders.

Those who do enter the field find payment rates by commercial and public insurers to be low compared with customary charges. In 2002, the average private insurance reimbursement for a 45- to 50-minute session of individual psychotherapy with medical evaluation and management was \$47.95 less than the average charge of \$155.59. Medicaid rates are even lower. In California, for example, the difference between reimbursement and customary charges is more than \$100.⁶ In addition, most insurers pay the same rate for child psychiatrists as for adult psychiatrists, which does not account for the extra time needed to consult with family members and school personnel.

Numerous surveys find that payment rates are driving child and adolescent psychiatrists out of the public and private insurance market, which is now dominated by managed care. A 2002 national survey conducted by the American Academy of Child and Adolescent Psychiatry found that 44 percent of these psychiatrists were accepting new patients who use Medicaid, 65 percent were accepting patients who used unmanaged private health insurance, and 53 percent accepted new patients with private managed care. "The lower the supply of child psychiatrists, the more they are in demand, which enables them to get out of managed care. I have heard anecdotally that many young graduates don't join managed care, they go into the cash business," says Dr. Wun Jung Kim, director of child and adolescent psychiatry at the Medical College of Ohio.

The number of child and adolescent psychiatry residency programs decreased from 130 in 1980 to 114 in 2002. The combination of low payment rates, reduced federal support for child and adolescent residency training (the Balanced Budget Act of 1997 reduced direct graduate medical education funding by 50 percent for subspecialty training), and the closure of state hospitals, which housed many of these training programs, likely underlies this shrinking of programs.

Pediatricians — Pediatricians and family physicians are being called on to identify, and often treat, the mental health problems of children. From 1979 to 1996, the rate of psychosocial problems flagged by pediatricians or family physicians increased from 7 percent to 19 percent of all office visits by children.⁷ And it is striking that these doctors prescribe 85 percent of all psychotropic medications taken by children.⁸ (In contrast to child psychiatrists, there is no shortage of pediatricians in the United States, although there are areas of the country where they are few. By 2020, the number of pediatricians is expected to rise by 60 percent, whereas the child population is expected to grow by less than ten percent.)⁹

Numerous surveys find that payment rates are driving child and adolescent psychiatrists out of the public and private insurance market.

“When I first started to practice in 1979, I never thought I’d see the amount of ADHD and depression that I’d have to manage today,” says Dr. Joseph Hagan, a Vermont-based pediatrician and co-chair of the American Academy of Pediatrics (AAP) Bright Futures Committee, which publishes practice guidelines on a range of issues, including mental health. Dr. Hagan notes that pediatric residency programs are increasing their behavioral and developmental training requirements, and pediatricians are clamoring for continuing medical education opportunities in this area. In the meantime, “developmental pediatric skills among experienced, board-certified pediatricians varies,” he wrote in a 2001 commentary published in *Pediatrics*.¹⁰

To help fill this knowledge gap, in 2000 the AAP released specific guidelines for identifying and treating ADHD, the number one mental disorder treated by primary care physicians and the condition that accounts for the largest number of children on psychotropic medication. Guidelines have not yet been published for other mental disorders, such as depression, obsessive-compulsive disorder, and conduct disorders.

In addition, in 2002, the American Board of Pediatrics created a formal subspecialty called developmental and behavioral pediatrics, with its own training and certification standards. The specialty includes three years of formal pediatric training followed by three years of fellowship, clinical work, research, and community-based service. Because the subspecialty is so new, it is difficult to project whether a substantial number of pediatricians will gravitate toward it. So far, 300 have become board certified, and more than 200 are scheduled to take the exam (given every other year) in 2004.¹¹

Dr. Hagan believes that pediatricians can handle medication management for children with a variety of mental disorders, although more complicated cases involving multiple diagnoses, as well as severe conditions, would probably best be handled by psychiatrists. But one problem, he says, is that many pediatricians do not have access to psychiatrists with whom to consult about treatment. “If I’m going to [prescribe], I need to be able to consult. When I want a murmur assessed by a pediatric cardiologist, I can get that. But I can’t get [similar consultation] for psychiatry,” Dr. Hagan says.

Pediatricians are also calling for changes in managed care reimbursement policies as they spend more time identifying and treating mental health disorders. A major concern, echoed by psychiatrists, is that managed care payment rates do not reimburse for the time physicians must spend talking to family members and teachers to assess whether a child has a particular disorder. In addition, many plans do not reimburse pediatricians for time counseling patients and their family members about their conditions. Another large criticism regards the mechanism of capitation, in which providers receive fixed monthly payments for each patient, no matter what their utilization. Many argue that capitation deters pediatricians from taking the time to address psychosocial problems.

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Non-Physician Prescribers — To deal in part with the shortage of psychiatrists, New Mexico and Louisiana have become the first two states to grant prescribing privileges to psychologists who complete specialized training. At least a dozen other states are considering such a move. The American Psychological Association has applauded such measures, noting that psychologists bring an expertise in assessing and treating mental illness that general practitioners—who are allowed to prescribe psychotropics—do not. They also point to studies that suggest that a combination of talk therapy and medication is the most effective way to treat mental illness, thus allowing psychologists to prescribe might lead to more efficient care.

Psychiatrists are wary of this expansion. “Prescribing medication is very complicated. You have to know a lot about drug interactions, how they metabolize and interact with various organs. We [psychiatrists] go to medical schools for four years to learn about these things,” says AACAP president Dr. Anders.

The National Alliance for the Mentally Ill (NAMI), one of the nation’s largest advocacy groups for those with mental illnesses, shares this concern. NAMI has stated that when it comes to people with severe mental illnesses, whose medications can cause toxicity if not carefully monitored, psychiatrists are the most suitable provider.¹²

Meanwhile, the American Psychological Association notes that accessibility is an issue of concern: there are 444 counties in the United States that lack psychiatrists but have psychologists.¹³ New Mexico is giving credentials to psychologists to prescribe medication in an effort to boost access in its rural areas. (Psychologists are on staff in many rural-area schools there.) But allowing psychologists to prescribe drugs may not solve the rural access problem in other states. Most mental health providers in rural areas are bachelor’s degree-level social workers, notes David Lambert, president of the National Association for Rural Mental Health, which represents 500 consumer, provider, and research groups in the rural United States.¹⁴

Non-Prescribing Mental Health Providers

Over the past 40 years, practice patterns in mental health care have shifted dramatically. In the 1960s, when very few psychotropic drugs were available, most of the psychiatrist’s work day consisted of psychotherapy. Today, psychiatrists are doing much less psychotherapy and increasingly are specializing in drug treatments. Managed care has made this economically more attractive—psychiatrists can be reimbursed substantially more per hour for providing medication management rather than just psychotherapy, or a combination of that with drug treatment. Even outside managed care, psychiatrists can earn more per hour doing medication management than psychotherapy.

However, there is now a greater variety of professionals trained to offer psycho- and behavioral therapy, such as psychologists, clinical social workers, and counselors, and thus there is more substitutability. Many, if not most, managed care organizations (MCOs) have policies that favor the use of social workers for talk therapies over psychologists. Social workers are either reimbursed at a lower rate than psychologists or are more willing to accept the MCO reimbursement rate for psychotherapy. Many MCOs include a higher mix of social workers than psychologists on their provider panels. In others, case managers encourage patients to use social workers.

The disparity in training among the disciplines has raised questions about how well social workers and counselors can help children with mental disorders. The minimum credential for social workers (who numbered 468,000 in 2000, although 97,290 were clinically trained)¹⁵ is a bachelor's degree, but many positions require a master's degree. For the most part, health plans require clinical social workers on their provider panels to have a master's degree plus two years of experience. Most counselors (who numbered 20,000 in 2000) have a master's degree. In contrast, it takes seven years of post-graduate training to become a psychologist (88,490 in 2002).¹⁶

Increasingly, concerns have been raised about the quality of training for all disciplines and their ability to deliver care that demonstrably improves the patient's condition.

EVIDENCE-BASED CARE

Just as they have swept the physical health world, evidence-based treatments are now being developed for children's mental health care to determine which medications, psycho- and behavioral therapies, and service strategies work best for a variety of conditions. The field is in its infancy. So far, evidence of effective strategies has been produced in university-based settings for a number of conditions such as depression, attention deficit hyperactivity disorder (ADHD), and anxiety and conduct disorders. But for the most part, these practices are not being used yet in real-world settings.

To qualify as a mental health evidence-based intervention, the treatment must work in more than one study using a randomized experimental design. However, there are no uniform standards developed for this field of science as of yet. The American Psychological Association has created rigorous criteria for defining effective psychotherapies. Another group that determines whether pharmacology treatments, as well as school-based interventions, are effective is the Interdisciplinary Committee on Evidence-Based Youth Mental Health Care, a joint effort of the AAP, the AACAP, and the American Psychological Association.¹⁷

These organizations' studies of mental health have yielded some observations. When it comes to psychotherapies, parent training improves behaviors for children with conduct disorders and oppositional behavior.

Many, if not most, managed care organizations have policies that favor the use of social workers for talk therapies over psychologists.

Using non-phobic people as models of behavior and using reinforced practice can help children with phobias. For kids with depression, cognitive-behavioral therapy—where children learn coping skills and new ways of thinking instead of just discussing how they feel—has been shown to make a difference.

“What we see most commonly in usual practice is something called processing of experience or reflection. The therapist asks about the patient’s week. ‘Tell me about the argument. How did you feel about it?’ The session becomes an opportunity to have a sympathetic person think through the experience together [with the patient]. But usual practice is often not as structured or agenda-driven as evidence-based procedures,” says Dr. John Weisz, an expert in children’s evidence-based treatments and director of Harvard University’s Judge Baker Children’s Center.

“The difference between many forms of usual practice and evidence-based treatments is that [such treatments] have a skills-building agenda,” Weisz says. The therapist might ask “‘What thoughts did you have when you had this experience with your friend? Was that a realistic thought? What would be a more realistic way to think about that experience?’” Weisz says these questions would “have goals to build specific coping skills.”

Although there has been a tremendous growth in psychotropic medication use among children, there is little research on its safety and effectiveness. Most of what is known about such drugs that are approved by the Food and Drug Administration (FDA) comes from studies of adults. The FDA is only allowed to approve a medication for a defined population, but, once approved, physicians are allowed to prescribe the drug for anyone—a practice known as “off-label” use. The drug manufacturer, however, is only allowed to market the drug to the FDA-approved population.

The FDA has approved few psychotropic drugs for children’s use. Stimulants such as methylphenidate (for example, Ritalin) have been approved for treating ADHD. According to the surgeon general’s report on mental health, ADHD is the only condition for which there is a solid research base that medication works and is (at least in the short-term) safe.¹⁸ A major government study found that stimulants are more effective than psychotherapy alone in treating ADHD.¹⁹ However, the success hinged on close medication management, such as adjustment of doses once a month. Many children with ADHD have their medication checked much less frequently.

For treating childhood obsessive-compulsive disorder, the FDA approved in 1999 the use of two medications: fluvoxamine and sertraline (Zoloft).

To treat childhood depression, a growing number of medications in the class of selective serotonin reuptake inhibitors (SSRIs) are being prescribed for children, such as Prozac, Paxil, Celexa, and Zoloft. The FDA has approved only Prozac for pediatric use. Studies of antidepressant use among children have had mixed results, depending on the medication, and

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recently some studies have found increases in serious depression and suicidal thoughts and attempts by children using some SSRIs.²⁰

In response to public concerns, the FDA in March 2004 issued an advisory to clinicians, parents, and caregivers to “closely monitor all young patients on therapy with antidepressant drugs.”²¹ In June 2004, New York Attorney General Eliot Spitzer sued GlaxoSmithKline PLC, the firm that manufactures Paxil, for not publishing studies that showed negative impacts of Paxil on children.²²

A study published in August 2004 in the *Journal of the American Medical Association (JAMA)* found that a combination of Prozac and cognitive-behavioral therapy was the best method for treating adolescent depression. Seventy-one percent of the study’s participants who used this combination overcame their depression. The study, conducted by researcher John March and colleagues at Duke University and funded by the National Institute of Mental Health (NIMH), found that Prozac alone was effective in treating 61 percent of patients, whereas cognitive-behavioral therapy alone worked with 43 percent. Thirty-five percent of the study participants improved with a placebo.²³ The study also found a small but increased risk of suicidal behavior among children taking Prozac.

The link between children’s SSRI use and suicide was confirmed in September by an FDA advisory committee, which recommended that the FDA place a black box label—the strongest warning the agency could issue—on all antidepressant drugs to warn of the increased suicide risk among pediatric patients. The panel did not recommend a ban on antidepressants for children, noting that the drugs have shown benefit to some and that the risk of depressed children committing suicide if left untreated is higher than their risk for suicide on antidepressants. On October 15, 2004, the FDA announced the requirement of the black box warning on all antidepressant medications.²⁴

(Researchers have not been able to determine why antidepressants may increase children’s suicidal behaviors, but some theories are gaining attention. One posits that, during the first few days of use, the medication alleviates the lethargy felt by depressed children with suicidal thoughts, giving them the “energy” to act on such thoughts. Another suggests that, in some cases, children with bipolar disorder are misdiagnosed as having depression and prescribed antidepressants, which throw them into manic episodes that trigger suicide. Providers recommend closely monitoring children during the first ten days after beginning antidepressant use.)

The *JAMA* research has the potential for changing the way providers treat childhood depression. In an interview with National Public Radio, Dr. Harold Koplewicz, child psychiatrist and director of New York University’s Child Study Center, said he has been treating depressed teens by first using talk therapy and then moving to medication use. In light of this research, he told the reporter, “Today, if I had a teenager present with depression I would certainly tell [his or her] parents that

medication should be started immediately and after the patient was on medication, we would start cognitive-behavioral therapy."²⁵

Overall, the few evidence-based treatments that exist for children's mental health problems are highly regimented; manuals have been written for implementing many of them. For the most part, they are not being used yet in private practice, public clinics, schools, and hospitals. This is not to say that all mental health providers are giving ineffective care. Many clinicians use a combination of strategies that—through their own experience, intuition, and judgment—work. But because their practices have not been studied in randomized trials, they are not proven as effective.²⁶

Although the scientific approach to testing strategies and practices has also shed some light on what may not work in children's mental health care, many of these practices are still being implemented and reimbursed by health plans. For instance, experts now question whether a therapy known as "critical incident stress debriefing," in which trauma victims are encouraged to describe and vent their emotions within one to three days of a traumatic incident, is more harmful than helpful. Group therapy may actually increase behavior problems among high-risk teens with conduct disorders. A number of experts believe that psychotherapy without stimulants does little to help children with ADHD. Children with severe emotional disturbance who are placed in group homes often get worse once they return to their own homes, yet group homes continue to be used and payments for them continue to be reimbursed.²⁷

In this nascent field of evidence-based treatment for children's mental health, questions remain regarding the effectiveness of these strategies in real-world settings, such as clinics, schools, and providers' offices. Studies of such treatment have typically been conducted in university laboratories, where patients are chosen with a particular set of problems, and providers possess a known set of skills and experience. Many experts caution that conditions are not as tidy in the real world. Patients often come to the clinical setting with multiple disorders as well as family problems, such as parents' substance abuse. They may also terminate care early. In addition, providers may not strictly adhere to treatment strategies recommended in a manual, and more experienced providers may also resist new ways to treat their patients.²⁸

Not all agree that formalizing evidence-based care for children's mental health is a good move. Some providers believe that if it becomes the standard in professional training and a condition for third party payment, it will restrict their creativity in finding the best ways to help their patients. Others fear that once treatment strategies are formalized, researchers and practitioners will have little incentive to improve on them.

But because this movement is so new, evidence-based measurements for children's mental health care have not much affected managed care practice yet. "On evidence-based treatment, we're just scratching the surface," says Dr. Rhonda Robinson-Beale, chief medical officer for

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CIGNA Behavioral Health, which covers 14 million people. According to Dr. Beale, CIGNA examines the medication treatment plans for patients—adults and children—in inpatient psychiatric units, checking for cases in which the plan does not mesh with guidelines put out by the American Psychiatric Association.

Dr. Richard Frank, health economics professor at Harvard Medical School, concurs that behavioral health organizations are starting to use evidence-based treatment measures in the area of medication management for conditions that have well-documented treatment practices. They are starting with strategies to ensure patients are not only prescribed the appropriate medication but that they are taking it.

Dr. Frank believes it is premature to try to implement a uniform standard for evidence-based psychotherapy. “Having it stew out there in the world a little bit longer might be a better thing,” he says.

COMMUNITY-BASED SYSTEMS OF CARE

Provider supply and effective care for children’s mental health take on broader meanings when applied to community-based systems of care for children with severe mental illnesses. Since the mid-1980s, the trend in caring for children with serious emotional disturbance has shifted the focus of care away from psychiatric hospitals and toward community-based care—day programs, respite care for families, therapeutic foster care, and home-based counseling to stabilize families and prevent a child’s institutionalization. States and the federal government have taken the lead in creating such systems of care, using substantial funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) and Medicaid.

Public mental health systems for children across the states are experiencing workforce shortages. “There’s a cry from the children’s mental health directors in the states. They’re having a terrible time getting qualified people to come and work within the public sector,” says Joan Dodge, with the National Technical Assistance Center for Children’s Mental Health at Georgetown University. Ninety percent of states have reported difficulty in recruiting and retaining child welfare case workers,²⁹ and 21 state mental health agencies reported shortages of social workers in 2001.³⁰

A shortage of psychiatrists is particularly acute in the public mental health sector. Twenty-two state mental health authorities reported shortages of psychiatrists in state hospitals; 21 reported such shortages in community mental health programs. To deal with this, 25 states have allowed nonphysicians—a mix of nurse practitioners and physician assistants—to prescribe and/or monitor patients’ medications.³¹

Regarding effective systems of care, experts largely agree on what constitutes a quality system. For instance, systems that (a) are family-driven, (b) create care plans that incorporate parents’ needs, (c) are culturally and

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linguistically competent, (d) use case managers appropriately, and (e) employ staff who can work well across various agencies (schools, juvenile justice, child welfare, special education, public mental health) are considered quality systems.³²

A body of evidence-based care is also emerging for these systems of care. Among the findings, children released from institutions and placed in therapeutic foster care show better behavior and fewer rehospitalizations than those released to community care. One treatment showing extremely strong effects is multi-systemic therapy (MST). It is a short (3 to 4 month) program in which providers visit the home, sometimes daily, to improve not only the behavior of children who are at risk of entering the juvenile justice system but also the coping skills of family members. MST has significantly reduced out-of-home placements and arrests among these children.³³

But researchers note that workers in the public mental health system are largely ill-prepared to implement evidence-based care. "Rarely do professionals receive training in the values, skills and attitudes consistent with reforms that call for partnerships with families, cultural competence in service delivery, comprehensive cross agency interventions, individualized care and home and community-based approaches," note the authors of a paper published by the National Technical Assistance Center.³⁴

A number of states are taking steps to remedy these training deficits. Pennsylvania has formed a training institute that is part of its Child and Adolescent Service System Program (CASSP), which, with federal support, offers community-based care for children with severe emotional disturbance. The institute has developed a set of core competencies for providing mental health care for children in the public CASSP system. These include best practice models for individual care, public systems management, and working with families. The goal is that continuing education programs for various system providers will contain these core competencies.³⁵ In similar fashion, the Maryland Department of Health and Mental Hygiene in spring 2004 convened a strategic planning session with multiple stakeholders to develop strategies for the recruitment, retention, and training of professionals and paraprofessionals who work with children with mental health needs and their families.³⁶

SERVING MINORITIES

Culture—ethnicity, race, and shared norms and beliefs—has a distinct impact on mental health. It influences how patients manifest and communicate their symptoms, their willingness to seek treatment, and their networks of support, according to a 2001 surgeon general's report.³⁷ The report found that, although mental disorders are just as prevalent within minority populations in the United States, minorities are less likely to seek care, and the care that they do receive is often of a lower quality than care provided to non-minorities.

Although mental disorders are just as prevalent among minorities, they are less likely to seek care.

Minority representation, as well as a knowledge of how to approach people of different cultures, is lacking in the mental health workforce. Although 12 percent of the U.S. population is black, only 2 percent of psychologists, 2 percent of psychiatrists, and 4 percent of social workers are black providers.³⁸ Moreover, there are only 29 Hispanic mental health professionals for every 100,000 Hispanics in the United States, compared with 173 non-Hispanic white providers per 100,000.

Minorities are also poorly represented in studies of evidence-based treatments, according to the surgeon general's report. The surgeon general has called for targeted training funds to lure more minorities into the mental health professions, as well as greater participation of minorities in mental health research.

ACTIONS BEING TAKEN

To improve the children's mental health workforce supply and the practice of effective care, a number of actions are being taken in the public and private sectors.

Boosting Provider Supply

In March 2003, Rep. Patrick Kennedy (D-RI) introduced the Child Healthcare Crisis Relief Act (H.R. 1359), which would use educational incentives to lure more students into the children's mental health professions. The bill would extend Medicare graduate medical education funding to child psychiatry training programs and create a loan forgiveness program for child and adolescent psychiatrists. The bill would also offer scholarships and loan forgiveness to bolster the numbers of school psychologists and social workers, school counselors and psychiatric nurses. H.R. 1350 has 57 co-sponsors. A similar bill, S. 1223, was introduced in the Senate by Gordon Smith and has 13 co-sponsors.

Improving Provider Training

Experts have acknowledged a national crisis in the training of the mental health workforce, a problem that until recently has been driving the shortcomings in the quality and currency of mental health care for children in the private and public sectors. In order for evidence-based treatments to be practiced, they must be taught to students in the various disciplines and to professionals through continuing education. For the most part, this is not happening.³⁹ To address this and other training inadequacies, agents across professions as well as government have come together to form the Annapolis Coalition on Behavioral Health Workforce Education. The coalition's goals are ambitious and include developing an agreed-upon set of skills to be used in psychiatry, psychology, social work, counseling, and other professions providing mental health care, as well as improvements in methods of education and training.

The coalition, which receives SAMHSA funding, was founded by the American College of Mental Health Administration, a multidisciplinary body, and the Academic Behavioral Health Consortium, a nonprofit group comprised of university departments of psychiatry. In 2003 the coalition recommended to the President's New Freedom Commission on Mental Health that the federal government use a number of strategies to improve the behavioral health workforce, including instituting policies in federally funded health plans to promote appropriately prepared and supervised trainees.⁴⁰

Disseminating Best Practices

In partnership with the Annapolis Coalition, to promote best practices in mental health care, SAMHSA has launched a new "Science to Service Agenda" initiative. The initiative includes ongoing development of a national registry of effective programs and practices in mental health and substance abuse; 150 programs are listed thus far (see www.modelprograms.samhsa.gov). SAMHSA is also offering a range of grants to help public mental health systems implement evidence-based practice and develop the most effective ways to reduce service gaps.⁴¹

In terms of improving care practices, the MacArthur Foundation is funding a major effort, the Network on Youth Mental Health, which is reviewing the evidence for therapies to treat the most common childhood disorders and testing methods of delivering evidence-based practices in community mental health centers. The initiative is also studying organizational and payment policies that discourage providers from practicing evidence-based care and will use this knowledge to develop ways to share evidence-based practices with a variety of clinics and providers.

LOOKING TOWARD THE FUTURE

There have been dramatic shifts in the composition of the children's mental health workforce, in the way that each discipline defines its role, and in the knowledge of talk therapies and medications that improve children's mental health problems. Combined with the large demand for services, these changes have created more questions than answers about how services should be delivered, who should deliver them, and what interventions should be used.

Experts have offered a number of projections. One is that clinical social workers, in the future, may assume the role of today's psychologists in providing extended psychotherapy. Psychologists, in turn, would provide the care typically offered now by psychiatrists (for example, prescribing and monitoring medication), and psychiatrists would become specialists in the biomedical aspects of mental illness. Richard Scheffler, a health economist at University of California, Berkeley, offered this scenario in a 2003 article that appeared in *Health Affairs*.⁴²

In the future, clinical social workers may assume the role of today's psychologists in providing extended psychotherapy.

Another scenario is that the development of core competencies in children's mental health may eventually erode the concept of separate disciplines (social work, counseling, psychology, psychiatry) in favor of skill sets. Dr. Ron Manderscheid, chief of the Survey and Analysis Branch of SAMHSA's Center for Mental Health Services, posits that once a core set of requirements is developed, providers' expertise would be distinguished by their mastery of serving a unique population, such as minority children, or those with serious emotional disturbance.

Some experts can already project the kinds of changes that evidence-based practices will require of the workforce. They are likely to call for additional training for specific procedures, such as MST, and a re-tooling of skills to practice strategies, such as cognitive-based therapy. New knowledge in SSRI treatment could require providers to manage their practices differently to keep close track of patients' reactions to drugs, says Dr. Kelly Kelleher, director of the Office of Clinical Sciences at Children's Research Institute in Ohio and professor of pediatrics at The Ohio State University.

Others acknowledge that evidence-based treatments, with their regimented manuals and practice guidelines, could allow providers without doctoral credentials (for example, clinical social workers or master's level counselors) to have just as much of a chance of improving patient outcomes as psychologists. Two pioneers in this field, Dr. Kimberly Hoagwood at Columbia University and Dr. John Weisz at Harvard, note that the bulk of evidence-based talk therapies could conceivably be delivered by master's level clinicians. This calls into question the need for providers with higher credentials to provide front-line mental health care.

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