Children Australia
Volume 41 | Number 3 | pp. 237–239 | © The Author(s) 2016 | doi:10.1017/cha.2016.23

Commentary
Mental Health Services for Children: Concerns and Challenges

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Background

At various times in my career, I have focussed on mental health services for children and their basis in human rights principles. This year I returned to examining best practices and how they could be implemented in a particular place – the State of Illinois, in the United States, where I reside. I found myself reflecting on improvements in services over the last 40 years, but even more, on the significant challenges and gaps in our knowledge that remain. I want to focus this commentary on two topics I found most salient: Contradictions between principles and practice; and need for more research on how to provide services in the most restrictive settings – inpatient and residential.

I am also troubled by recent conversations with young practitioners – social workers and a nurse – on the front lines of trying to help children with serious emotional disorders and their caregivers. The social workers, based in schools, were telling me they could get children into inpatient care when needed, but that care was disconnected from the child's life before and after the hospitalisation. One example entailed no communication from the inpatient staff until the child was discharged with a referral to follow up weekly with the child psychiatrist. Inpatient staff seemed to be unaware that no such professional existed in the city where the child lived.

In another example, the nurse in a publically operated inpatient setting was frustrated with training given staff, which, whilst important in the abstract, did little to help with the daily challenges. All staff had to attend sessions on trauma-informed practice when they were struggling to know how to help teenagers who had psychiatric and intellectual disorders in addition to significant behaviour/conduct issues, such as attacking their caregivers both in the community and in the hospital. I began to think that we were failing not only the children but the professionals who give their all to providing the best care possible.

Perhaps, this commentary will inspire both thought and action.

Children's Rights Framework for Mental Health

Soon after the adoption of the United Nations Convention on the Rights of the Child (UNCRC), I collaborated with several scholars on the development of a framework to understand the hodgepodge of rights set forth in the UNCRC (Brieland, Korr, & Bretherton, 1991; Brieland, Korr, & Fallon, 1993). I applied the model to mental health policy (Korr, 1993). The model defines three types of rights: (1) *entitlements* – what children can expect from parents and society, including government if necessary; (2) *protections* – avoidance of harm, e.g., from abuse or exploitation; and (3) *affirmative freedoms* – similar to self-determination rights of adults, rights to think, act and make decisions as they are able.

For the purpose of this commentary, I will focus primarily on the most salient mental health *entitlements*. From Article 23:

> States parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which insure dignity, promote self-reliance and facilitate the child's active participation in the community.

And, from Article 29:

> Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

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Article 23 sets out the overall vision and goals. Article 29, whilst it focusses on child victims, reflects important principles undergirding the design of mental health services – they should promote recovery and reintegration and take place in environments that foster the dignity of the child. The latter is often interpreted as meaning the 'least restrictive environment'. I prefer to argue that it means that all environments in which care is provided must foster the dignity of the child.

Contradictions between Principles and Practice

Unfortunately, we know all too well that principles and practice might not match. First, I want to highlight some principles, in addition to the ones above, that typically guide the design and provision of mental health services for children: the use of evidence-based practices, promotion of choice by families and children, and fiduciary responsibility. Whilst the first two are deeply embedded in the education and practice of mental health professionals, the third is not always explicitly considered. Considering the expense of treatment, whether that is a cost to families or to government, and ultimately a cost to citizens, we need to be the best stewards of the resources being used to provide treatment so that we can achieve the goals of recovery and reintegration.

In practice, mental health services for children are increasingly provided in the community, but inpatient and residential services remain highly utilised, and often sought out by families and caregivers. A study of Medicaid expenditures (the largest public funder of services in the US) for behavioural health for children found that the largest percentage (19.2) was for residential treatment and therapeutic group homes with another 5.4% for inpatient psychiatric hospitalisation (Pires, Grimes, Allen, Gilmer, & Mahadevan, 2013).

Whilst there is evidence that intensive community services in a Systems of Care model can bring benefits to children and families (Stroul, Pires, Boyce, Krivelyova, & Walrath, 2014), one national study of children referred for child welfare services found that 25% had an intensive, restrictive setting as their first out-of-home care (James et al., 2006). In fact, in environments that emphasise community-based treatments and cost controls (e.g., through managed care), we have reason to expect that those children referred for inpatient or residential care have serious impairments, typically including multiple conditions and behavioural/conduct problems.

Reviews of effectiveness of treatment for mental disorders in children and adolescents have found few controlled studies of residential or inpatient treatment and conclude that more research is needed on both (Blanz & Schmidt, 2000; Burns, Hoagwood, & Mrazek, 1999). I could not find evidence that research has been conducted in the years since those papers were published.

Concerns and Challenges

Human rights principles guide us to promote recovery and reintegration of children with mental disorders and to do so with respect for dignity of the person. However, we still know that children with severe problems will find their way into expensive inpatient and residential care. We have far too little research on what is effective treatment in those settings. Whilst accrediting bodies such as the US Joint Commission have now promulgated National Quality Measures, they offer little guidance (The Joint Commission). Measures include: having a justification for putting the child on multiple antipsychotics; having a continuing care plan; and, transmitting it. Those activities are important, but they do not provide guidance to direct care staff on effective treatment approaches, nor do they assess whether the continuing care plan is appropriate (see above story of the referral to the non-existent child psychiatrist).

If, as suggested by Blanz and Schmidt (2000), we should see child psychiatric inpatient services as the equivalent of intensive care services in medicine, perhaps we can utilise innovations being developed in health care delivery. Use of implementation science to create 'learning health care systems' is particularly promising (Chambers, Feero, & Khoury, 2016), suggesting that: research and practice can coexist; that evidence-based practices have to work in real world settings; and that perspectives of multiple stakeholders (including patients, administrators, researchers, and policy makers) are needed.

Some children will continue to need out-of-home care. I hope we can begin to find ways to make that care effective in achieving the outcomes of recovery and reintegration.

References

Blanz, B., & Schmidt, M. H. (2000). Practitioner review: Preconditions and outcome of inpatient treatment in child and adolescent psychiatry. *Journal of Child Psychology and Psychiatry, 41*(6), 703–712.

Brieland, D., Korr, W. B., & Bretherton, D. (1991). Freedoms, entitlements, protections and parents rights: An analysis of the UN Convention on the Rights of the Child. *Children Australia, 16*(2), 15–18.

Brieland, D., Korr, W. S., & Fallon, B. J. (1993). The United Nations Convention on the Rights of the Child: A conceptual model. *Children at risk proceedings.* K. Ekberg & P. E. Mjaavatn (Eds.). Bergen, Norway: Norwegian Centre for Child Research.

Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Chld and Family Psychology Review, 2*(4), 199–254.

Chambers, D. A., Feero, W. G., & Khoury, M. J. (2016, May 10). Convergence of implementation science, precision medicine, and the learning health care system: A new model for biomedical research. *JAMA Network, 315*, 1941–1942.

James, S. E., Leslie, L. K., Hurlbeurt, M. S., et al. (2006). Children in out-of-home care: Entry into intensive or restrictive mental health residential care placements. *Journal of Emotional and Behavioral Disorders, 14*(4), 196–208.

Korr, W. S. (1993). The UN Convention on the Rights of the Child: Implications for mental health policy. *Children at Risk Proceedings* (pp. 70–82). K. Ekberg & P. E. Mjaavatn (Eds.). Bergen, Norway: Norwegian Centre for Child Research.

Pires, S. A., Grimes, K. E., Allen, K. D., Gilmer, & T. Mahadevan, R. M. (2013). Faces of Medicaid: Examining children's behavioral health service utilization and expenditures. Center for Health Care Strategies.

Stroul, B., Pires, S. A., Boyce, S. Krivelyova, A., & Walrath, C. (2014). *Return on investment in systems of care for children with behavioral health challenges.* Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.