BACK TO THE BASICS:
PARADIGM SHIFTS FOR CHILD-ADOLESCENT MENTAL HEALTH SERVICES

By
Arlene Rubin Stiffman, Wayne Stelk, Thomas Sexton

Article Abstract
The child-adolescent mental health system is failing to meet the needs of its constituent populations. This paper goes “back to the basics” by considering how the prevalent paradigm in Child and Adolescent Mental Health Services (CAMHS), with its attendant assumptions, impacts and shapes activities of our research, practices, preparation of practitioners, and health policy. The complex CAMHS system must become more responsive to children and adolescents with emotional/behavioral disorders. Tinkering with and modifying the existing system will not result in more effective service delivery. Instead we need a new paradigm that targets all components of the system for fundamental change. This paper identifies the broad parameters of failures in the current child-adolescent mental health system. From the critiques, we propose the development of new paradigms based on an understanding of systems theory.
BACK TO THE BASICS:
PARADIGM SHIFTS FOR CHILD-ADOLESCENT MENTAL HEALTH SERVICES

The Medical Model of Child Mental Health as a Reductionistic Paradigm

The Child- Adolescent Mental Health Services (CAMHS) system confronts clinically complex youth with high rates of behavior problems, diverse mental health disorders, criminal behavior, and other “at risk” behaviors (e.g. school truancy, family conflict etc.). However, it is increasingly apparent that the system has serious problems. Research has been unable to demonstrate that the current system is effective in helping the clients, the providers, and communities successfully overcome the myriad of problems facing children and youth. As with most types of mental health care, the current system is based on an individualistic medical model approach of assessment, diagnosis and treatment.

We have spent decades tinkering with the CAMHS system to improve and fix it. We have used a number of service models or paradigms to understand it, beginning with the Andersen model (Andersen, 1968), a simple medical model to describe individual illness, access, and then treatment. Over the years, this early individualistic model has evolved with additional focus on the context (the environment, including the provider relationship) (Andersen, 1995). Subsequent research has added to our understanding of various elements of this model (Costello, Pescosolido, Angold, & Burns, 1998; Pescosolido, 1996; Stiffman, Pescosolido, & Cabassa, 2001). Still, each iterative attempt to fix the system fails to result in any significant improvement in the care provided to children, adolescents and families in the mental health system.

The medical model of mental health for children and adolescents has expanded in scope beyond the disabling biological conditions of schizophrenia, depression, and anxiety. What we diagnose as mental illness now includes a wide range of behaviors that are considered “deviant” in the context of family, school, and society. Because the medical model assumes a disease process to account for maladaptive behavior, this disease perspective has skewed research, practice, and health policy away from other approaches that can be more effective in meeting the needs of children, adolescents, and parents.

Rather than continuing to mis-label many of our children and adolescents as “mentally ill,” we must find other approaches that build help families to learn better ways of adapting to the demands of their intra- and extra-familial environments without the stigma of mental illness and get out of the “revolving door” of ongoing care.

Our approach in this paper is to go “back to the basics” by considering how the prevalent paradigm in child-adolescent services, with its attendant assumptions, impacts and shapes activities of our research, practices, preparation of practitioners, and health policy. We reflect on the degree to which these assumptions may fit with current research and practice knowledge bases. Our idea is that the actions taken within the different components of the CAMHS system are guided by a prevalent paradigm that shapes activities both in the parts and the whole. Therefore, in order to transform the system, we must understand current failures within various
components of the CAMHS system. Only then can we apply new paradigms that will lead to positive change.

The paradigm prevalent in the mental health industry is that of the medical disease model. This is an essentially reductionistic paradigm that posits a disease process as the causal factor for non-normative behavior and distress. Cognitive, emotional, or behavioral symptoms are matched to a medical-psychiatric diagnosis for which treatments are prescribed. The medical/disease model of mental health reduces arbitrarily-defined, groupings of behavior to a single diagnosis that justifies a type of treatment for which the specialist receives diagnosis-related fee. The practice culture established by this paradigm is that the specialist, by virtue of extensive training, knows the best approach for alleviating the problematic behaviors, if the individual will only cooperate. The very words “mental health treatments” imply actions on an individual, rather than with an individual.

If the medical model paradigm has evolved beyond the point of being effective, then we need to return “back to basics” by questioning the premises that shape our research, practices and health policies. We need a new paradigm that will contain the medical model to its rightful place of treating disordered biological processes, and will foster more effective help to families who experience disordered social processes. In order to build a foundation for a new paradigm, we must first understand the power of any paradigm to shape individual and institutional perspective and practices.

The Effect of Paradigms on Health Perspectives and Practices

In his treatise on scientific revolutions, Thomas Kuhn (1962) described paradigms as models or patterns that shape a worldview. When paradigms change, our view of the world literally changes with them. As Kuhn describes, paradigms establish a culture of perception in which ideas and practices are self-reinforcing (Sterman & Wittenberg, 1999). Depending on the degree of adherence to the paradigm, practitioners are at risk of ruling out evidence that might contradict the premises of the paradigm (Groopman, 2007). Given the power of paradigms to shape worldviews, we need to back to the basics by carefully examining the core premises of any paradigms that are adopted for a science of “mental health.”

Our task is no less than critiquing and changing a system that is driven by the powerful and pervasive paradigm of “mental disease” in children and adolescents. The difficulty of this task is illustrated by Bateson’s observation that those within a systemic paradigm are usually incapable of acting as the change agents needed to disrupt the system. As he famously observed: “it is only the fish that don’t know that it is water in which they swim.” In other words, once embedded in a system shaped by a paradigm, change becomes difficult. Change that makes small improvements and adjustments does not result in major shifts in direction.
Implications of a Reductionist Medical Model of Child Mental Health

Because the current CAMHS is rooted in a medical paradigm, we assume that the problems of the child and family problems are “clinical,” that clinical assessments lead to a diagnosis of those problems; and that treatments will be offered that fit the specific diagnosis. Implicit in these practices are several assumptions: that the prevailing etiological models are accurate; that a “diagnosis” accurately reflects the problems of children and youth; and that treatment must be based on a finely tuned assessment of the diagnosis. This medical model of mental health may be helpful for the most debilitating biological disorders, such as schizophrenia, depression, and anxiety; but we must come to appreciate that the medical model is a “box” that limits our ability to think in new and different ways – which is the effect of prevailing paradigms. Treatments based on the medical model are not a “bad” way of doing business; but this model is based on a set of assumptions that often precludes implementation of a different way of thinking about clients, treatments, organizations, and environmental contexts.

While the medical model has merit with regard to severe mental illness in children and their parents, it is not useful in addressing the social/environmental context that may support specific problems or the social/environmental problems themselves. Later in this paper, we will consider a new paradigm for social/environmental problems. Non-medical models of mental health do exist, but they are being practiced within a care delivery system that is structured to fit a medical model. With one hand, we acknowledge the importance of environment in affecting behavior; but with the other, we persist in the very same assumptions of the medical approaches. We focus our energies and finances on treatment and services for those with problems without putting equal emphasis on trying to change the environment so as to either prevent or ameliorate problems. Even many of our “newest and best” treatments (typically called “evidence-based treatments”) largely adopt the assumptions of the medical model paradigm. In CAMHS, the medical model and its core assumptions are, we suggest, the factor that is currently limiting our ability to improve our system of care by moving to a full multisystemic approach. The diagnosis of mental illness carries with it the implicit association of a clinical problem affecting a particular individual, rather than a multisystemic problem resulting from and inextricably tied in with community, family, parents, peers, history, and culture.

As mental health professionals working within structures shaped by the prevailing paradigm, we need to see the “water in which we swim.” We assume that there is or needs to be a “diagnosis,” the validity and accuracy of which is rarely contested. We have many examples of diagnoses for mental illnesses that we now know were just wrong (Sroufe, 1997). A primary example is that of homosexuality, which was only removed after political action, but which never should have been considered an illness. In another example, early diagnostic measures had no option for avoiding diagnoses such as depression when the depression was clearly the natural result of life factors (Tracy, Zimmerman, Galea, McCauley, Stoep, 2008). All variations of human expression and behaviors should not be considered illnesses (Kaplan, 2006). We now have an opt-out if depression is due to grief. But what about depression when one is chronically physically ill? Or when life offers no hope? Or when childhood is ruined by abuse? Or when families are homeless? The question is whether these “labels” are accurate, instructive, and even helpful.
The assumption of diagnosis also carries another assumption—that we need to increasingly refine our diagnostic categories, and that in doing so, we will improve the care we provide. For example, with adolescents, the broad category of “behavior problems” cannot be reduced to a specific diagnosis based on the assumption that such labeling is valid, useful, and will improve treatment.

Many of our most treasured assessments of mental illness, the ones upon which individual treatments and national estimates are based, have little test-retest reliability. For example, expert clinician diagnoses have low agreement rates (Garber, 2006) and the standardized Diagnostic Interview Schedule (DIS) has consistently shown that rates go down dramatically at the second administration (Robins, 1995). The increasing specificity of “diagnostic categories” promotes the illusion that by fine-tuning the “diagnosis,” we can better provide treatment. In the world of physical medicine, that may be true; but in the intrapersonal world, further diagnoses may actually focus attention on the description of problems and the assessment of such problems, rather than on the treatment of them.

The act of diagnosis is an act of paradigmatic reification that creates a set of assumption regarding treatment, providers, and systems of care. The act of diagnosis within the medical and individualistic approach also has implications for what is an appropriate treatment. When problems are marked by diagnosis and assessment, it tends to be psychiatrists and clinical psychologists with advanced training in these domains that are the sanctioned treatment providers. Thus, the very assumption of what is a problem ultimately dictates who provides treatment and what type of treatment that might be. Such thinking ultimately results in a self supporting cycle perception and action.

The Multisystemic Model of Family Health as a Holistic Paradigm

In order to understand children and adolescents we must look beyond the reductionist paradigm of the medical model. We need to evolve holistic paradigms that expand our perspective to include the broad context of people’s lives. Children and adolescents are dynamic living systems. Their strengths and problems are based upon interactions between their internal genetic/biological predispositions, as well as their family, community, and school environments. Through research, we are uncovering more and more evidence that all aspects of environment (intra-person, family, peer, community, and even society) are important with respect to problems that are social in nature, as well as even severe psychiatric disorders.

Starting at the most basic levels of environment, we can document the importance of the social and physical environment as a determinant of behavior (Van der Linden, Drukker, Gunther, Feron, & Van Os, 2003). We now know that the brain itself, as well as neuronal pathways, can be reshaped by one’s environment (Rutter, 2006). We can actually visualize the process and outcome of such reshaping. Further, we have found that certain mental illnesses, known previously to be genetically and structurally related, can be triggered by stressful environments. For example, a predisposition to schizophrenia can remain just that, a predisposition, until a major life stress occurs (Jones & Murray, 1991; McDonald & Murray, 2000). Depression, similarly, is known to be related to environmental stress as well as biological causes (Feinberg,
Button, Neiderhiser, Reiss, & Hetherington, 2009; Tracy et al., 2008)). For decades we have documented that violence, conduct disorder and antisocial behavior is more likely to occur when environmental controls are absent or when the environment provides models or reasons (like discrimination, hopelessness, and hatred) for such behavior (Farrell & Sullivan, 2004; Liberman, 2007; McKay, 2005). A predisposition to addiction is heritable, but its triggering requires the presence of the addicting substance and a proximal environment of access and/or encouragement (Curran, White & Hansel 2000; Yu & Stiffman, 2007).

The link between environment and human development is well-known (Leventhal & Brooks-Gunn, 2004; Stiffman, Hadley-Ives, Elze, Johnson & Doré, 1999). The stress that children endure when they are raised in impoverished communities with low collective efficacy affects their behavior and symptomatology (Sampson, Raudenbush & Earls, 1997 & 1998). Children who grow up in poor neighborhoods are more likely to witness chronic community violence that lead to educational delays, physical and mental health problems, and other behavioral disorders, including the likelihood of learning violence themselves (Farrell & Sullivan, 2004). Even the most resilient of children who have very supportive families will succumb to behavior problems in a sufficiently stressful environment (Vanderbilt-Adriance & Shaw, 2006).

We have evidence that when a child or adolescent’s environment is improved, some mental health problems decline. For a long time, there has been evidence from communities throughout the United States that rates of violence, burglary, and theft decrease when the economy improves, and increase during bad economic times. However, researchers’ fears of making aggregate errors by assuming causality have pushed those data to the background. Nevertheless, some more recent research on American Indian communities has uncovered similar results. Costello (Costello, Compton, Keeler & Angold, 2003), and Stiffman (Stiffman, Alexander-Eitzman, Silmere, Osborne & Brown, 2007) found, in studies of American Indian youths, that when the economic outlook of the community improved, the youths’ mental health also improved.

The “multisystemic perspective” maintains that all people are living systems, made up of multiple internal systems that interact with multiple external systems (Bronfenbrenner, 1979; Skyttner, 2005). Each of these internal and external systems is dynamic in that the components of each system are interconnected and interdependent. As such, no one system can be isolated from other systems, and no one system can be reduced to its component parts. The child and the clinician are both living systems whose behaviors are guided by the multiple other systems operating within their personal internal and external environments. Because of the dynamic interactions between these internal and external environments, neither the child nor the clinician can be viewed in isolation of their personal context. In contrast to the medical model of mental disease, the multisystemic paradigm views people as whole persons who are continuously evolving through the dynamic interaction with their social and physical environments. People are not static and they are more than the sum of their behaviors. The multisystemic model characterizes the individual having multiple internal systems (physiological, hormonal, neurological, cognitive, emotional, behavioral, etc.) that form an adaptive relationship with multiple external systems (family, neighborhood, school, peers, job, human service agencies, culture, etc.). Even more important is that a truly multisystemic view focuses on the relationship between the parts as just as important as the parts themselves.
We propose that this multisystemic perspective is a more appropriate paradigm for understanding and explaining the strengths, problems, and challenges faced by children and adolescents. This paradigm views children and adolescents in the context of their families, and their families are viewed in the context of their social and economic environments. This is an expansive view of children and adolescents that stands in contrast to the reductionistic practices of a medical paradigm. The multisystemic perspective holds that children and adolescents cannot be helped in isolation of the family and environment that contribute to shaping their behavior. To adopt such a perspective means more than adopting and “co-opting” the term multisystemic. It means that systems of care, treatments within those systems and the organizational structures that surround them have a different basic assumption regarding the definition of problems, the manner in which it is addressed, and the ways help is supported.

The structures and infrastructures of the current mental health care delivery system that have developed under the guise of the medical model are in need of fundamental change. In order for alternative paradigms, such as the multisystemic perspective, to evolve, new structures and infrastructures must be built. The multisystemic perspective is not new to the field of child and adolescent mental health. The systems perspective has informed mental health practice with youth and their families for decades (Becvar, 2003). However, the full impact of these holistic and contextual perspectives has been constrained by the demand of medical model structures for diagnosis, medically justified treatment, service payment schemes based on diagnosis, and graduate training curricula that confer the title of specialist for the treatment of a narrow range of diagnoses.

The shift from a medical paradigm of child-adolescent mental health to a multisystem paradigm will not happen simply because some constituency thinks it should be so. As noted earlier in this paper, paradigms shape the way we see the world, which in turn shapes the structures of our world. We will therefore next turn to a consideration of the structural changes that must occur if a paradigm shift from a medical model of mental health to one of a multisystem model is to succeed.

The Paradigm Shift: Challenges of Transitioning to a Multisystemic Perspective of Child-Adolescent Mental Health

The Paradigm Shift: Training Mental Health Practitioners

Based on the medical model, the work force for mental health services is made up of practitioners who hold graduate or medical degrees, complete a post-graduate internships or residencies, and become certified within their particular discipline (professional psychology, social work, marriage and family therapy, rehabilitation, etc). The paradigm (implicit or explicit) that is reflected in the curriculum shapes the graduate students’ perspective about his/her professional identity. The type of licensure defines a culture of treatment privileges and determines who is a professional and who is not. These cultures of professional exclusivity preclude the contributions of paraprofessional who may have experienced their own mental
health problems and who, with training, can offer families the unique perspective of having “been there” themselves.

Our graduate schools provide an entry level education into the world of children’s mental health work. However, the world of CAMHS is one in which our practices and the work of practicing clinicians is dynamic…a domain that changes over time. This means that finding a way to provide continuing support for practicing clinicians is a critical element in the field. In children’s mental health there are a number of areas of support that might be critical for improving CAMHS.

Unfortunately, the responsibility for continuing training and support is placed on the individual clinician, the organization for whom they work, but not by the field. Regardless, there seem few incentives and opportunities to get systematic training in the newest developments in the field or use those practices. Similarly, there is a lack of incentive to incorporate new approaches into existing practice systems. There is little organizational push to start, train, and bring new practices to their potential. When treatments are delivered the measures to improve quality, usually both clinical and administrative supervision, is more documentation of than a process of improving practice. Supervision is focused on “crisis intervention” and “peer support” rather than on a systematic process of learning and developing. The field is also shackled by a lack of financial incentives to support or retain clinicians, provide incentives to develop new practices, or to encourage new learning and innovation.

The Paradigm Shift: Researching Evidence-Based Practices Based on the Multisystemic Perspective

Evidence based practices (EBP) are the current state of the art for practice in CAMHS. While there are currently few established, tested, and disseminated practices, approaches based on and validated by science have great potential to provide models of effective treatment (urns, Hoagwood, & Mrazek, 1999; Hoagwood, Burns, et al., 2001;). The EBP approaches in CAMHS and the EBP movement have been criticized for not being clinically responsive, being based on single types of research (Randomized Clinical Trials), and not being focused on the unique characteristics of the youth and families served. In some cases these criticism represent more of the fear and worry of change among clinicians and educators. In other areas even the EBP suffer from the same lack of specification of treatment, inattention to the relational process required for clinical implementation, and a general “black box” approach in which the mechanisms of action are not well understood or well articulated. In addition, many of these models are also based on broad general principles and not specific mechanisms. Thus, despite their potential, many of the EBP repeat the same mistakes and replicate the same problems as earlier approaches. So, despite their potential their likely adoption is questionable.

In some cases these criticism represent more of the fear and worry of change among clinicians and educators. In other areas even the EBP suffer from the same lack of specification of treatment, inattention to the relational process required for clinical implementation, and a general “black box” approach in which the mechanisms of action are not well understood or well articulated. In addition, many of these models are also based on broad general principles and not specific mechanisms. Some of the “evidence based” models are either “cook book” steps of
treatments that lacks a relational and systemic focus or are based only on broad and general principles that give little guidance to the treatment provider or researcher. For example, some approaches call for the emphasis on family engagement and empowerment without specifying the specific and relational mechanism through which that might occur. Other approaches herald their focus on “strengths” without articulating and describing the clinical processes to do so. Other approaches integrated “individual therapy” or “family therapy” without specifying what type, what approach, or what clinical mechanism are contained in those treatments.

For example, The Systems of Care movement, the most current approach in CAMHS, speaks little to the issues of the specific treatments provided to children and adolescents. Using a medical model analogy, this is a little like paying more attention to the delivery mechanism (the pill or shot) rather than the active ingredients of the medicine that is delivered.

Other evidence based models have basic assumptions that don’t fit the clients. For example, many require consistent caring parenting when many parents are overwhelmed by poverty, addictions, illnesses, abusive spouses/partners, etc. These are the very families whose children are most likely to have problems. Thus the people with the most need are least likely to be able to access/pay/use/understand/benefit from current clinic based treatment models. Further, the very neighborhoods most likely to spawn children with multiple problems are those least likely to have clinical resources that can mount such services. The typical approach is to call for more funding, more treatment providers rather than consider the basic assumption of the treatment models currently in place and looking at the multisystemic whole.

When models of practice are multisystemic, they don’t “fit” into the current medical model environment. True Family based treatment models are a good example. As one type of evidence-based treatment they have great potential in providing help to children. However, the basic unit of analysis in family treatment is the “family” and the relational connections between family members rather than the individual themselves. Because they don’t fit the individualistic approach of the medial model they are difficult to incorporate into the mainstream of the CAMHS system.

Thus, despite their potential, many of the EBP repeat the same mistakes and replicate the same problems as earlier theoretical approaches, common factors, and tool box models. So, despite their potential their likely adoption is questionable. As Kazdin (2008) suggested, until we understand the “mechanisms” of treatment we really know very little about what we do.

The Paradigm Shift: Implementing Evidence-Based Practices Based on the Multisystemic Perspective

There has been a surprising lack of attention to implementing evidence-based practices in the real world (Stelk, 2006). Despite promising findings, a significant gap exists in translating family evidence-based treatments (EBT) into community settings. The emerging evidence suggests that even though evidence-based family treatments may be effective in research trials, they don’t always translate to programs into community settings under less controlled non-clinical trial study conditions (more clinically realistic) with children, adolescents and their
families (Hoagwood, et al., 1995; Rowe & Liddle, 2003; Sexton & Alexander, 2002). In a sobering finding, Henggeler (2007) found that effects are consistently lower for EBTs implemented in real life clinical settings compared to laboratory settings and that those reductions were on the order of 50% lower. The question is why?

Three issues related to a multisystemic framework emerge as most salient explanation for the lack of successful translation of evidence based treatments (EBT) into community settings: adherence to guidelines; the realities of family complexity; and the assessment of outcomes.

1. Adherence to Guidelines: A substantial body of current research supports the importance of adherence to treatment guidelines and therapist competence as key reasons why efficacious treatments may fail in community-based settings (Henggeler, et al. 1997; Hogue, et al., 1996; Sexton & Alexander, 2002; Waltz, Addis, Koerner & Jacobson, 1993). Studies of adherence in family-based intervention programs have demonstrated that for efficacious programs to be effective in community settings, the programs must be consistently delivered in a manner that adheres to the models’ specifications (Barnoski, 2004; Sexton, Sydnor, & Turner, 2003).

However, the issue of specific adherence to a program model is more complex. It seems that adherence to a specified model of treatment may be necessary for some outcomes, but that strict adherence to an EBT protocol does not ensure improved clinical outcomes. For example, Morgenstern, et al. (2001) found no difference in clinical outcome when comparing clients whose therapists rigidly adhered to the EBT versus clients whose therapists flexibly implemented the given program. Henggeler and colleagues also found that while various aspects of adherence affect key outcomes, no global relationship between adherence and outcomes could be found (Henggeler et al., 1997; Henggeler, Pickrel, & Brondino, 1999). In fact, both Hogue et al (2008) and Barber et al. (2006) found that a curvilinear relationship may exist between therapist model adherence and clinical outcomes. These studies suggest that while therapist model specific adherence may be important, we are far from understanding its role in the mechanisms of clinical change. Viewing adherence from a multisystemic framework may help reveal environmental or other system variations that explain why, where, and how flexibility rather than strict adherence might be indicated.

3. The Realities of Family Complexity: In a clinical setting with a true multisystemic approach, diversity is represented by the complex nature and severity of clinical problems, the family and community relational contexts, as well as culture, race and ethnicity of the clients (among other factors). Work has been done to understand the range of client problems for which family-focused EBTs are effective (Sexton et al, 2003). However, little work has been done regarding the effectiveness of evidence-based interventions for culturally and racially diverse youth, families, and communities. Given the well-documented disparity in mental health and juvenile justice, cultural sensitivity and applicability is becoming one of the most important implementation issues in juvenile justice and child and adolescent mental health systems. A true multisystemic paradigm incorporates diversity as a central, rather than a peripheral, element.
4. The Assessment of Outcomes: Multisystemic points of view do not focus only on a single outcome. For example, in a true multisystemic model, avoiding treatment would be as important as receiving it. Within the medical model paradigm, outcomes are typically specified in terms of the original diagnoses, ignoring any concomitant assessments of environment or functioning. In a true multisystemic environment, outcome would be multivariate. It is time that we in children’s mental health services focus on all aspects of the whole. This would make it harder to assess a particular EBT, but would better reflect reality. Monitoring and using model-specific multisystemic outcome information could be both encouraged and enhanced with computer technology (Bickman, 2008; Bickman, Riemer, Breda, & Kelley, 2006). Using computer technology, these methods could not only monitor the process of change, but also provide feedback information in a “real time” manner so that it is immediately available to clinicians and can reflect ongoing personal and environmental changes.

What we need next are public policies and service payment models that support the implementation of evidence-based treatments that embody the multisystemic perspective.

The Paradigm Shift: Public Policies and Service Payment Models

Policies are instructions that establish the parameters of allowable behaviors of participants within institutions or organizations. Policies operationalize the paradigms that are core to the mission of the institution or organization. The federal agency, the Centers for Medicare and Medicaid Services (CMS), is driven by medical paradigm that includes physical and mental health services. Consequently, clinicians who seek reimbursement for services through CMS must have treatment practices that conform to CMS regulatory policies. As such, a person seeking help for a cognitive, emotional, or behavioral disorder must be given a medical diagnosis, and the clinician can only offer particular types of services that are “medically necessary.” Through a variety of waiver programs, state mental health agencies can offer non-medical services (such as peer support by a non-licensed counselor), but all waiver services provided to Medicaid recipients must be associated with diagnosable medical conditions that are supervised by licensed clinicians. Through CMS policies, and comparable policies of commercial insurers, clinicians must shape their clinical practices based on a paradigm that allows payment only when a medical diagnosis is applied to a person’s life circumstances.

For community mental health centers that depend on federal-state and commercial insurance, the demand that all services be justified as “medically necessary” precludes a whole-person, a whole-family, or a person-environment approach. For example, suppose a family has recently immigrated to the United States and is experiencing high degrees of stress due to the relocation, an entirely new culture, and lack of resources. Under Medicaid regulations, the family as a unit cannot be seen a unit. One member of the family would have to be identified as the “client,” who must be given a medical diagnosis. Family therapy would be an option, but all billing must be associated with the identified client. Should the father, as the identified client, present with anxiety, the clinician may be precluded from going with the father to sign up for public benefits because such a service would not be reimbursable. Given the pressure a clinician feels to generate billable hours in order to make revenue quotas, the clinician may feel sympathetic to the
father’s plight, but can do no more than advise him on how to negotiate a complex system with which he is completely unfamiliar.

While a community mental health center may want to adopt a whole-person paradigm in their services, regulated payment constraints preclude the adoption of a more desirable paradigm.

Conclusions: Disseminating and Adopting New Paradigms

We wish it were possible to lay out a clear picture of a “new paradigm.” That, however, is the work of future iterations in the evolution of CMHS. We do suggest that if we are to successfully shift from a medical paradigm of child-adolescent mental health to that of a multisystemic paradigm, we must rethink of the core ‘medical model’ approach to understanding clients, diagnoses, treatment and the organizational structures that support these models.

We need to adopt true “multisystemic” approach to helping. We don’t suggest that all approaches to help can or should address each component of a multisystemic system. What we need is a continuum of approaches all different in their primary approach, each with well articulated and tested mechanisms of change, implemented in community settings with support for their maintenance and growth each with the same basic assumptions. We are not suggesting that to be multisystemic each way of working needs to address either the family or the environment. What we do suggest is that we look beyond the labels to the assumptions of the work and that the approaches in this continuum all share the same view that children, youth, and their families are more than individuals with problems. They are complex individuals, within complex relational systems, living in context that is cultural, social, and environmental. We do suggest that these ways of helping should work together—each doing a part of helping people “function” within this complex multisystemic world.

Adopting this approach would mean that it is time to stop the “medicalization of normality” (Frances, as cited in Beam, 2009) and “pathologizing entirely natural responses to hunger, humiliation, financial insecurity, and racism” (Tsao in Beam, 2009). We have to distinguish between disease and dis-ease. We can do this by using assessment as a triage for services by using a full multisystemic perspective. We must make sure that our environmental assessment is not secondary to the individual mental health assessment, or side-lined by a drive to find a label of disease. We must target, as a prospective goal, not just the individual’s behavior, but, equally, whatever aspect of the individual’s internal or external system is dysfunctional.

This approach would suggest that the very definition of treatment would expand to embrace all types of interventions. Disease would be that which is largely related to the internal individual systems and thus be appropriate for treatment of the individual. In contrast, dis-ease arises due to a lack of fit or support from an environment, be that parents, school, community, etc. For disease, the intervention of choice would be working with the external system, be it on the basis of an individual’s immediate system (like most EBTs) or larger community systems (consistent with the social work and public health perspectives). For some children, both types of approach would be needed. It would mean a change from a wide range of specific diagnoses to more expansive assessments.
The change from a notion of mental health services as treatment to mental health services as multisystemic intervention would require a sea-change in how treatment is conceived and how funding is allocated. As Bateson says, change in one part of the system, from within the system, is nearly impossible. Yet instead of continuing to throw money and energy at tinkering with our present approach, we need to go back to the basics and strive for fundamental change in the very structures and processes that maintain the status quo.

Change would mean that this multisystemic view would be supported, funded, and adopted by all levels of the system. Human service is a field with a demonstrated lack of financial incentives to support and retain clinicians, provide incentives to develop new practices, and encourage new learning and innovation. A successful child-adolescent mental health system is one that must be incentivized to address problems from a full multisystemic perspective.

Change at all levels of the system (clinician, the care delivery system, service payment plans, federal policy governing research and funding) must involve structural changes and content changes. Structural change for the clinician addresses the issues of training – graduate school and post-graduate. Content change deals with what we teach the clinician and how we define the mental health services workforce. Structural change at the community level must address resources, policies, and knowledgeable management. Content changes at the community level would be the manner in which services are delivered and monitored for quality. Structural changes at the state and federal level have to do with payment policies (fee-for-service is killing us), accountability mechanisms, and infrastructure support for service development and clinical training. The content changes at the state and federal level would be new standards of care that reflect the new paradigm.

We will not make these changes happen by simply writing and talking about them. Real change will occur only when academics, providers, and policy makers together view the world through a different lens and take actions to create a new order in the field child-adolescent mental health services.
References:


**Missing references:**

Barber et al. 2006
Barnoski, 2004
Bateson