APPENDICES

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APPENDIX A

Council on Children's Mental Health

Appendix A
Interagency Systems of Care for Children's Mental Health
(Council on Children's Mental Health)

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All children function within multiple systems, usually including their families, schools, communities, and primary health care. Children experiencing emotional and behavioral problems require services from additional systems such as mental health, substance abuse, special education, intellectual and developmental disabilities, child welfare, or juvenile justice. Care is optimal when systems are organized to coordinate and integrate these services. Coordination of services is essential for all children involved with more than one system, but is even more important for the children and adolescents with multiple agency involvement, whose care has historically been uncoordinated and fragmented. The community-based System of Care (SOC) philosophy is designed to address these needs. It emphasizes an individualized and flexible approach striving to coordinate and integrate care and provide services in the child's home and community whenever possible.

This practice parameter was written to reflect these paradigms and approaches inherent SOC philosophy. It serves as an overarching set of principles and practices that are broadly applicable to community-based practice. It is not intended to duplicate other practice parameters on assessment and treatment, and will therefore emphasize aspects of clinical practice particularly important in SOC. It is also not intended to duplicate parameters on specific areas of community-based practice, such as treatment of specific populations of children in the community (e.g., children in foster care), or mental health services in specific settings (e.g., school-based consultation; mental health in juvenile justice settings). Instead, it focuses on practices recommended across all populations and settings.

This parameter addresses community mental health care in SOC at three levels: (1) independently practicing child and adolescent psychiatrists and other mental health clinicians who apply SOC principles; (2) mental health care delivered in community settings such as community mental health agencies, school-based mental health programs or other educational settings (e.g., Head Start programs), juvenile justice facilities, child welfare settings (e.g., therapeutic foster homes), or primary health settings; and (3) mental health care delivered in an organized "system of care" containing structural elements supporting integration and coordination of services, flexible funding, and wraparound planning

processes. These organized systems of care facilitate individualized services such as intensive home- or community-based interventions. Community-based practice may also include administrative consultation to local and state health and social service organizations.

Recommendations

Recommendation 1. Clinical assessment and treatment approaches should be guided by an understanding of the ecological context of the child and family, incorporating information from community systems (formal and informal) with which they are involved.

The child and adolescent psychiatric assessment as applied in a clinic or office practice focuses on the child, his/her nuclear family, and his/her functioning at home, in school, and with peers. The assessment yields a diagnosis and target symptoms and behaviors to be addressed by the treating clinician. Assessment should be expanded for children with serious emotional and behavioral disorders served in community systems of care, who may already be involved with multiple agencies and treatment settings. Their families typically face multiple stressors and may encounter barriers in accessing treatment. The assessment process should incorporate a broad social ecological framework, taking into account a multiplicity of environmental and systems factors (Henggeler et al., 2001; Pumariega & Winters, 2003b; Woolston et al., 1998).

The social ecological perspective conceptualizes human development as a reciprocal interchange between the individual and "nested concentric structures" mutually influencing one another (Bronfenbrenner, 1979). The individual is embedded within interconnected systems, including the family system (and the extended family) and the extrafamilial systems, such as school, work, peers, and primary health care, and the larger community and cultural institutions that are part of the child and family's life experience, such as religious institutions. Systemic issues (e.g., legal, social, or financial) impacting care are also part of the child's ecological system.

Ecologically targeted interventions may include addressing barriers to care (e.g., home-based services or transportation to appointments) or accessing strengths and resources in the child's natural environment that can promote positive change. For example, identification of a helpful adult who is already present in the child's natural environment and might become a formal mentor or provide part-time employment can be a potent intervention. Since children are involved in many systems, it is also essential that adequate time be allotted in the evaluative process to gather ancillary data and communicate with other providers, in addition to having adequate time to interview the child and family.

Recommendation 2. The clinician should develop collaborative relationships with families, emphasizing partnerships at both the case planning and system planning level.

One of the most important contributions in the past two decades of system reform has been the growth of the family and movements that focus on users of services. In systems of care, families are included as partners in all levels of the system, including leadership roles in system design. Family advocacy organizations have taken a leadership role in mental health advocacy, system planning, quality improvement, program evaluation, parent education, and development of parent mentoring programs (Friesen and Stephens, 1998). The development of partnerships with families has been associated with a shift from conceptualizing the family as the source of (or significant contributor to) the child's

pathology, to collaborating with parents, other family members, and parent advocates as partners in treatment. The parents' knowledge of their child, family, and culture is seen as equal in importance to the clinicians' knowledge of child development and psychopathology.

Recognition and support of the child and family's strengths allows for development of effective child and family teams in which parents can assume the natural functions of case management and self-advocacy. The family drives the team process by defining the desired outcomes and selecting individuals to add to the team. The team's function is to help identify how best to support the needs of the child and family. The child and family team should promote a climate of collaboration, respect, and trust. Family-centered approaches have been recognized as improving the quality of care and contributing to increased satisfaction of the service recipient (Friesen and Stephens, 1998). An example was a parent with several special-needs children who was spending her entire week at appointments recommended by multiple providers who had never communicated with one another. On noting repeated missed appointments, one of the clinicians suggested convening a child and family team meeting. At the meeting, the parent's accomplishments in caring for her children were acknowledged. She was able to share the burden of this situation and felt supported in her requests that the number of appointments be reduced.

Recommendation 3. Mental health interventions should be actively coordinated with services by other providers, including primary care providers, and, whenever possible, integrated with interventions provided by other social agencies.

Mental health is one of six components in systems of care for children, in addition to primary health care, education (including Early Intervention services and special education), child welfare, juvenile justice, and developmental disabilities. In addition, in most communities, chemical dependency and substance abuse services reside in a separate agency. Most children are involved with more than one provider or agency, most often primary health care and regular education, and issues of coordination begin to apply even at this level. Children with complex needs are generally served by multiple agencies and without active coordination of care; these children are at risk of receiving fragmented care that fails to address their overall needs.

Service coordination and integration can occur at the case, program, and larger system level. The clinician should actively promote coordination and integration of services at each of these levels. At the case level the clinician is most effective when collaborating with other providers to make strategic use of available services and ensure that care is coordinated. For example, the clinician can collaborate with the Early Intervention specialist to advocate for child welfare-funded respite services to help the parents keep the child in the home. The clinician may also advocate for mental health services to be integrated into the classroom setting for a particular child. The clinician can facilitate consistency of communication across providers by attending child and family team meetings, either in person or by video/teleconferencing, providing information about diagnosis and treatment options to the team, and serving as a liaison to the child's primary care provider.

At the system level, the clinician can promote integration and collaboration by advocating for interagency structures and agreements, which may include sitting on an interagency collaborative council. Facilitating collaboration within an agency is also important. Such activities are enhanced by familiarity with the philosophies, mandates, and financial and organizational structures of the different child-serving agencies. These characteristics impact the agency's ability to collaborate at the clinical and

system level. Availability to provide mental health consultation to primary care providers is another critical element in promoting collaboration and integration of care.

There is growing evidence for effectiveness of integrated mental health services delivered in settings such as schools, juvenile justice settings, and early childhood programs such as Head Start (Porter et al., 2003; Heffron et al., 2003). Clinicians may advocate for service integration and be available to consult in these settings. Not infrequently, it is difficult to get funding for these activities. In such cases, clinicians may actively advocate for and explore opportunities for funding interagency activity as a way to increase the effectiveness of their role. Child and adolescent psychiatrists can be important consultants in these settings for diagnostic and treatment purposes. It may be necessary to join with other professionals in the community to establish the importance of child and adolescent psychiatry's role in these activities.

Increased service integration presents both opportunities and challenges in the area of patient information and confidentiality. Information sharing across service providers in the case of a multiagency-involved youth is essential to effective service coordination. Organized systems of care have the potential to create informational databases that can be readily accessed in crisis situations. However, increased information sharing requires a heightened sensitivity that these are privileged documents, and the clinician should participate in safeguarding them against potential misuse. The clinician must also comply with state confidentiality requirements (which may vary across states) and the federal Health Insurance Portability and Accountability Act (HIPAA).

Recommendation 4. Services should be culturally competent and should address the needs of underserved, culturally diverse, at-risk populations.

More than 40 percent of all children and youth in the United States are from diverse, non-European racial and ethnic backgrounds, and this figure is expected to rise to more than 50 percent by the year 2030. Children and youth from non-European backgrounds and their families face many disadvantages, including socioeconomic and educational disparities, language barriers, social discrimination, and lesser opportunities. Their cultures are distinctly different from those of European origins, with different beliefs, values, normative expectations for development and adaptive behaviors, parenting practices, relationship and family patterns, symptomatic expressions of distress, and explanations of mental illness (Pumariega, 2003). Because of these differences, culturally diverse children and their families have many specific mental health needs relevant to assessment, treatment approaches and modalities, and support services. Unfortunately, the failure to meet such needs has contributed to increasing mental health disparities in these already vulnerable populations. Studies support the presence of significant racial and ethnic disparities in a number of areas relating to children's mental health, including access to community-based services, accurate diagnostic assessment, access to evidence-based interventions, increasing rates of various forms of psychopathology in some populations, and significantly higher rates of out-of-home placements and institutionalization (particularly in child welfare and juvenile justice) (U.S. Department of Health and Human Services, 2001; Pumariega, 2003). In addition, there is evidence of subtle differences in the metabolism of psychopharmacological agents in diverse populations, related to both genetic and environmental (e.g., dietary) factors (U.S. Department of Health and Human Services, 1999).

Children's mental health services should be provided within the cultural competence model. This model indicates the need to address the special mental health needs of diverse populations through both

clinician-related factors (such as acquiring knowledge, skills, and attitudes that enable them to serve populations different from their own) and system factors (such as reviewing and changing policies and practices that present barriers to diverse populations, staff training around cultural competence, and the recruitment of diverse staff and clinicians for planning service pathways and delivering care). This model also calls for the use of natural strengths and resources in diverse communities and cultures that are protective and support children and families dealing with emotional disturbance. It also includes the adoption of evidence-based culturally specific therapeutic modalities (such as use of native healers or cultural mediators), ethnopsychopharmacology practices, and the appropriate use of language interpreters (Pumariega, 2003).

The cultural competence model has been operationalized in consensus health and mental health cultural competence standards, such as the CMHS standards (CMHS, 1999), the Office of Minority Health (2001) Cultural and Linguistic Standards, and state-specific standards such as the state of California Cultural Competence Standards (1997). These standards address cultural adaptations and modifications in clinical processes (such as assessment, treatment planning, case management, and linguistic support) and system processes (such as staff training and development, access protocols, governance of service systems, quality assurance and improvement, and information management). There is beginning evidence that adopting such practices results in improved access to services and retention in treatment (Pumariega et al., in press).

Recommendation 5. *To achieve individualization of care for children with significant mental health needs, clinicians may use a wraparound planning process*

Wraparound is an integrated planning process that knits together services from all involved providers to address the strengths and needs of the child and family. It is an essential tool in the system-of-care model. The wraparound process should be guided by a comprehensive clinical assessment specifically addressing diagnostic and treatment issues (Solnit et al., 1997). The wraparound process as formally defined is most effectively applied in an organized system of care in which the focus of service planning is the child and family team with an assigned facilitator, and in which providers are encouraged to devote time to attending interagency meetings.

Even in less developed or organized systems, however, elements and principles of the wraparound process can be incorporated. For example, use of a strength-based orientation and discussion of needs rather than problems promotes more active engagement of families in service planning activities. Team members can think strategically about how to use system resources most effectively to meet the individual child and family's needs. The complementary contributions of various team members can work synergistically to promote better outcomes.

Interventions should be designed to reinforce strengths of the child and family. For example, a youth at risk for substance abuse might receive funding for prosocial activities such as lessons in horseback riding or a health club membership to decrease the risk of association with substance-using peers. Strength-based approaches may include nontraditional therapies such as skills training or mentored work experiences that remediate or offset deficits. For example, a youth might be given a mentored job experience in a family restaurant where the restaurant owners' adult son can coach him on developing more positive social behaviors. These interventions generally are not included in traditional categorical mental health funding and may require flexible funds that are not assigned to specific service types.

Through providing a balance of formal services and natural supports, wraparound plans can build a level of service intensity rivaling that of inpatient or residential settings, without removing a child from the home. A number of studies of the wraparound process in different communities with diverse populations of at-risk children and families have reported positive outcomes in terms of reduction of externalizing behavioral problems, level of function, reduction in out-of-home placement, improved family management skills and function, and service recipient/family satisfaction (Burchard et al., 2002; Kamradt and Meyers, 1999). The wraparound process is best suited for children and their families with complex mental health and related needs who have not benefited from traditional services.

Recommendation 6. Treatment planning in systems of care should incorporate effective interventions supported by the available evidence base.

Wraparound as a process alone may not be effective if the specific interventions themselves are not effective or if the skills and training of clinicians providing care are not adequate. Therefore, interventions with the strongest evidence base should be prioritized in clinical and systems planning. Evidence-based interventions such as cognitive-behavioral and other therapies for specific disorders should be incorporated (McClellan and Werry, 2003; AACAP, 2007), as well as evidence-based community-based interventions (Burns and Hoagwood, 2002).

One of the most evidence-based community-based interventions is multisystemic therapy (MST), an intensive, home-based wraparound model that combines a variety of individual and family interventions within a systemic context. MST has been evaluated with youth at risk of detention/incarceration and at risk of psychiatric or substance abuse hospitalization, with significant results in reducing out-of-home placement, reducing externalizing problem behaviors, reducing rates of recidivism, and lowering costs of treatment (Henggeler et al., 2001; Henggeler et al., 2003). Surgeon General Reports on mental health (1999) and on youth violence (2001), in addition to the President's New Freedom Commission, point to research evidence supporting the effectiveness of a number of other community-based interventions for children and youth such as intensive case management, therapeutic foster care, partial hospitalization, and intensive in-home interventions. Other community-based interventions that show promise include school-based interventions, mentoring programs, family education and support, crisis mobile outreach teams, culturally appropriate family support services, and time-limited hospitalization with coordinated community services (U.S. Department of Health and Human Services, 1999; Burns and Hoagwood, 2002; Rogers, 2003).

Recommendation 7. An interdisciplinary approach should be nurtured in systems of care programs, with all treatment being delivered in such a context. This includes both clear definitions of disciplinary roles and contributions as well as flexibility in these when necessary for the best outcomes for children and families.

> a) ***Child and Adolescent Psychiatrists: Child and adolescent psychiatrist may function in multiple roles in a system of care, including assessment, triage, direct service provision (psychosocial therapies as well as pharmacotherapy), consultation to other service providers, quality improvement, program design and evaluation, and advocacy.***

Child and adolescent psychiatrists have broad training in child development, biopsychosocial psychiatric assessment, psychosocial and pharmacological treatment modalities, risk assessment and crisis

intervention, and systems/organizational processes. Consequently, there are many possible roles in systems of care in which these skills can contribute to the quality of care delivered. Potential roles for child and adolescent psychiatrists include not only direct service provision (e.g., biopsychosocial assessments, triage, level or intensity of care determinations, and provision of ongoing treatment), but also agency- or system-enhancing activities (e.g., facilitating team building and interagency collaboration, participation in wraparound child and family teams, staff training, program development, medical leadership, and involvement in quality improvement and outcomes monitoring).

Often dilemmas arise around agencies' need for physicians to prescribe medications for a large population of children, at times attenuating opportunities for other roles that are equally important to the provision of quality care (e.g., consultation to primary therapists, collaboration with teams, and contributing to program development and evaluation). It is important in such situations for physicians to explore mechanisms to broaden their involvement and add additional value to the agency processes. Examples might include training and consultation to other clinicians to improve intake and triage operations, supervising other medical professionals to expand the medical resource, assisting the agency or program in selecting the most appropriate evidence-based interventions for the population, and using telemedicine or videoconferencing to increase opportunities for participation in team processes. Physicians should advocate for funding for attending interdisciplinary meetings, especially for children with complex psychiatric and medical issues. This may include advocating with insurance companies.

The child and adolescent psychiatrist may be a consultant, staff psychiatrist, or medical director in a variety of agencies, including governmental, private not-for-profit, public health, university, etc. It is important for the physician to advocate to be included in clinical and system planning meetings as part of the role when negotiating a position in a mental health or other child-serving agency. The role of the child and adolescent psychiatrist also includes advocacy at the community level through involvement in planning groups, professional advocacy organizations, publications or other contact with the media, and political advocacy.

> *b) Child psychologists*
> *c) Master's level therapists*
> *d) General psychiatrists*
> *e) Nurse Practitioners*
> *f) Primary care physicians*
> *g) Bachelors' level clinicians*

Recommendation 8. Pharmacotherapy should be performed by a physician or medical practitioner who is integrated in the interdisciplinary process and has completed a biopsychosocial assessment, including interviewing the child and his/her parent or caregiver and reviewing relevant ancillary data.

Growing awareness of the potential benefits of pharmacotherapy for children and adolescents has led to increased emphasis on the psychopharmacological role of the child and adolescent psychiatrist in community systems of care. This role is an important one, especially as newer and potentially more effective pharmacological agents continue to emerge. However, the biopsychosocial knowledge and skills of the child and adolescent psychiatrist are used most effectively as an integral part of the ongoing assessment and treatment planning process. Ongoing management may be provided by the child and adolescent psychiatrist, or the child and adolescent psychiatrist may function as a consultant. Systems of

care should promote the full integration of prescribing practitioners into interdisciplinary teams and integrate pharmacological therapies into children's wraparound plans. This should include systematic assessment of target symptoms, behaviors, function, and adverse effects by the whole team (including both synergistic and interfering side effects and such issues as optimal administration and dosing schedules). The team should also participate in the assessment of the efficacy of medications and interactions between pharmacotherapy and other treatment modalities and strength-based activities. Pharmacotherapy in systems of care should focus on functional improvement as well as on symptomatic relief. It should also include collaboration and psychiatric consultation around medication management with other prescribing medical professionals (Pumariega & Fallon, 2003).

It is important that practitioners of pharmacotherapy not practice in isolation from the rest of the treatment team and treatment planning process. Practicing in isolation runs counter to system-of-care principles and does not support coordination and integration of care. Constraints are frequently placed on the implementation of appropriate standards of practice, such as access to comprehensive psychiatric evaluation and adequate frequency and duration of medication management follow-up. Additionally, prescribing physicians may not have access to the inherent resources of system-of-care programs to inform pharmacological decision-making (such as multiple informants to evaluate the child's symptom patterns and function in different contexts, and child and family education and support for treatment adherence). Lack of adequate contact of the children and families with the prescribing physician or medical practitioner often leads to children and families feeling uninformed, disempowered, and mistrustful of pharmacological therapies (Pumariega & Fallon, 2003).

Prescribing physicians in systems of care should promote clinical standards for effective pharmacological therapy, including the use of evidence-based systematic assessment and symptom-rating tools and the use of evidence-based pharmacological interventions. They should become actively involved in quality assurance and improvement around pharmacological decision-making, practices, and therapies. They should also promote and implement training in psychopharmacotherapy for nonmedical mental health professionals and other child-serving professionals and staff in the system of care so as to better support the practice of psychopharmacotherapy and diminish stigma and distortion around this modality.

Prescribing physicians should promote the active involvement of children and families in pharmacological decision-making. This should be promoted through the physician's offering education about psychiatric disorders and pharmacotherapy, engagement around treatment selection, effective consent procedures that address perceived power differential and stigma, and engagement in the evaluation of efficacy and side effects so as to promote adherence. Informed consent must be obtained, ideally by the physician, but when this is not feasible at a minimum the physician should oversee the process and be available to answer questions of the parents or legal guardian. Attention should be given to cultural factors in pharmacotherapy, including consideration of ethnobiological factors, culturally appropriate decision-making and consent processes, and addressing issues of stigma and fears about the misuse of medications.

Recommendation 9. The clinician should be familiar with the organizational context of the agency or system in which he/she is working in order to advocate effectively for adequacy of resources and practices to meet the needs of children and families served.

The organizational culture and structure of a system of care or its component agencies largely influences and shapes the service delivery processes within the system of care, and the quality and effectiveness of such processes. These contextual factors determine the governance, funding mechanisms, resource allocation, accountability, communication, and quality assurance and improvement processes within such systems. Clinicians in systems of care should become familiar with agency and system administrative structures, mandates or contracted responsibilities, policies and procedures, and organizational culture. They should be able to evaluate the impact of system structure and function on clinical care processes and outcomes. They should also be familiar with quality assurance and improvement processes, including the evaluation of clinical and system outcomes and satisfaction of service recipients.

Clinicians should become involved in administrative and organizational processes as a means of advocacy for improved access and quality of care. As more emphasis is placed on fiscal and resource management during times of limited funding, there is an even greater need for effective advocacy for adequate resources to ensure necessary services for children and families as well as the maintenance of quality of care (Winters et al., 2003). Additionally, clinicians should be familiar with evidence-based community-based interventions and treatment modalities and advocate for their adoption within systems-of-care agencies and programs (Rogers, 2003).

Clinicians should participate in quality assurance and improvement processes and the evaluation of agency and systems outcomes (Friesen and Winters, 2003). As agencies and systems become larger and more complex, there is a danger of their becoming more impersonal and removed from the perspectives of clinicians as well as becoming less responsive to the children and families they serve and their local communities. Clinicians should advocate for local governance and accountability for agencies and systems of care as a means of balancing local community interests with corporate or governmental interests. They should also advocate for service recipient and family participation in governance and accountability processes (Vander Stoep et al., 2001).

Recommendation 10. The clinician and family share accountability for treatment success. The system of care should be accountable for clinical outcomes and actively involved in quality improvement efforts.

With increased societal demand for fiscal accountability, interest has grown in measuring outcomes for evaluation of individual mental health services and program effectiveness. Clinicians and health care administrators have also recognized that process is not by itself an adequate indicator of quality of care, and therefore clinical outcomes need to be measured. However, different stakeholders define desirable outcomes differently. Community systems of care for children or youth with serious emotional and behavioral disorders have many stakeholders, including the child, family, school, mental health or other service agency, primary health care provider, funding agency, etc. Local, state, and federal funding agencies are likely to prioritize cost and service utilization outcomes, whereas families are more likely to prioritize functional outcomes such as ability to function at home and at school and reduced family burden of illness (Friesen and Winters, 2003). Outcomes therefore need to be multidimensional. Several models have been presented as ways of conceptualizing different domains of outcomes that might be measured. Hoagwood et al. (1996) delineate five outcome domains: symptoms and diagnoses, functioning (i.e., the capacity to function within developmentally appropriate role expectations), service-recipient perspectives (e.g., satisfaction with care, family strain), environments (i.e., the stability of the

child's environment), and systems (e.g., change in utilization of services, restrictiveness of services, overall cost).

The system-of-care model entails accountability of the system for outcomes, also recognizing that functional outcomes may be as important to families as symptomatic improvement. Traditional services (and clinical research) have most often addressed symptomatic improvement and underemphasized functional issues more salient for day-to-day family life. In community systems of care, children and families who do not believe they are benefiting from services may either drop out or not comply with treatment recommendations. In the past, poor outcomes were blamed on family resistance or noncompliance, and such families were dropped from treatment. In these circumstances the clinician should identify what needs to be done differently to meet the needs of the child and family. A child or family dropping out of service should trigger review of the treatment plan rather than discharge from care. Different strategies may include offering home-based services or offering more culturally competent services. Setting different target goals for treatment or shifting the focus to functional issues that are more important to the child's parents may be required.

It is incumbent on the system (and clinicians working within it) to collaborate with families in deciding what the desired outcomes should be and share accountability with them for those outcomes. Families and service recipients have taken a more active role in some systems of care in developing outcome measures and approaches to program evaluation (Vander Stoep et al., 2001). These measures may convey information that is more meaningful to families. To be valid, system- and child/family-level outcomes should be derived from the planning process (Rosenblatt et al., 1998) and must be measurable and collected systematically. Clinicians share with the agency and system of care responsibility to evaluate the effectiveness of services and programs through quality improvement processes and formal evaluation procedures. Use of evidence-based interventions is likely to result in better outcomes. The recent review of evidence-based practice in child and adolescent mental health services by Hoagwood et al. (2001) makes the point that interventions found to be efficacious in rigorous laboratory conditions may not be transportable to community settings. Thus, interventions need to be tested in community systems of care using research designs adapted to community practice settings. Selection of evidence-based, outcomes-driven treatment approaches will be increasingly important as the stewardship of public funds comes under greater scrutiny.

Recommendation 11. Services should be delivered in the most normative and least restrictive setting that is clinically appropriate. Children should have access to a continuum of care with assignment of level or intensity of care determined by clinically informed decision-making.

It is a widely held clinical and societal value that children and adolescents are best served in the most normative setting possible, to provide them with the experience of living in a family and being a productive member of a community. Data on the efficacy of restrictive levels of care (e.g., hospital, residential treatment) have been mixed (U.S. Department of Health and Human Services, 1999). Yet youth with serious emotional and behavioral disorders are frequently at risk for placement in restrictive levels of care, separating them from their families and communities. Too often residential and hospital services are used because of unavailability of adequate community-based outpatient services. There are promising community-based interventions (e.g., MST, day treatment, therapeutic foster care, and intensive wraparound services) that may stabilize at-risk youth and allow them to remain in the community.

Redefining "level of care" as "intensity of services" encourages use of individualized services such as in-home supports or therapeutic mentoring, as opposed to placement in a "bricks and mortar" program. Other ways to achieve intensive community-based services include increasing levels of service coordination, team collaboration, and cross-agency involvement. Children should have access to a full continuum of services, with level or intensity of care determined by clinically informed decision-making rather than arbitrary protocols or benefit limitations. Assignment of level of care or service intensity may be facilitated by use of functional and level-of-care assessment methods, e.g., Child and Adolescent Functional Assessment Scale (Hodges, 1994), Child and Adolescent Service Intensity Instrument (AACAP, 2004), or Child and Adolescent Needs and Strengths-Mental Health (Lyons et al., 1999).

There are some situations, however, in which these restrictive placements are necessary and should be available, such as acute suicidality or psychosis, violent behavior, or serious sex offending disorders requiring safety and containment (AACAP Policy Statement, 1989).

Recommendation 12. Families and youth served by community systems of care should be empowered not only to actively participate in their own service planning and implementation, but also to assume critical roles in the governance of such systems and in service delivery.

Roles for families and youth in treatment planning

There is a growing recognition that family members and the youths themselves are critical members of their own treatment teams. Family members hold true expertise on their own children and have a primary decision making role in treatment planning. As Burns, Hoagwood, and Mrazek have pointed out, "It is becoming increasingly clear that family engagement is a key component not only of participation in care, but also in the effective implementation of it."(Burns, Hoagwood, and Mrazek, 1999).

The Federation of Families and the Center for Mental Health Services has adopted the following definition of Family-Driven Care:

> *Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This Includes:*
> * *choosing supports, services, and providers;*
> * *setting goals;*
> * *designing and implementing programs;*
> * *monitoring outcomes; and*
> * *determining the effectiveness of all efforts to promote the mental health and well-being of children and youth.*

Families should be respected as experts on their own children and enlisted as partners in the care of their children. Family involvement during all phases of service delivery, including participation on the service planning/ treatment team is required in order to have individualized services for youth (Wood, 2004).

There is a substantial amount of literature supporting parent involvement in service delivery. Increased parent involvement has been associated with treatment benefits including increased parental investment

in their child's treatment and outcomes, improved parent self-esteem, more positive role modeling for children, greater parent-professional collaboration, an expanded array of interventions and available supports, reduced lengths of stays in treatment environments, shorter stays in residential treatment services, and positive program feedback and satisfaction from parents (Worthington, Hernandez, Friedman, Uzzell, 2001).

Within the system of care environment, the Child and Family Team concept has emerged as a model service planning/ treatment team. The Child and Family Team include the family, the relevant professionals, providers, agencies, and any individual significant to and supportive of the family. The family often has a trained advocate who has learned to navigate the system also involved with the planning and the team meetings. The parent advocate is also a parent of a child with a serious emotional disturbance. The Child and Family Team accept the family as the primary decision maker and involve the youth whenever age and developmentally appropriate. The team bases its planning on the strengths based assessment of the child and family and relies on the child and family to set their goals, identify their needs, as well as their criteria for success. Services address the needs of the entire family, promote the connections between family and community, are flexible and accessible to families, and provide opportunities for learning and skill building. Families are given the chance to solve their own problems.

Families have emerged as effective monitors of their own child's success as well as effective interviewers, data collectors and evaluators (Osher, deFur, Nava, Spencer, Toth-Dennis, 1998).

Roles of families and youth in organizational governance

Families and youth bring valuable and insightful experiences to organizational governance and policy development. Their experiences are critical to system design, operation and evaluation. Family members and youth as policy makers can describe to agency administrators and providers how policy decisions affect their every day lives. The families and youths can describe their criteria for success and the importance of specific outcomes in programs and services. At the very heart of self-governance, is the right of individuals to be a part of the decision making when the policies and decisions affect their lives. Family members are important members of Child-Serving Agencies Advisory and governance councils, Mental Health Boards, Managed Care Councils, Children's Cabinets, Quality Assurance Committees, Council on Children's Mental Health and Consumer and Family Satisfaction Committees.

Roles of families and youth as providers and researchers

Families and youth have learned how to effectively provide quality mental health services including filling roles such as service coordinators/case managers, facilitators, interviewers, data collectors, data analysts, monitors, trainers, skill builders, advocacy, support group facilitators, peer-to-peer mentors, and researchers. Family members bring not only professional skills but also family experience and commitment to their roles. Families and youth have been instrumental in assisting researchers in understanding the needs of families, the criteria they have for success, what outcomes are important to families, and how to ask the questions critical in gathering the data as well as interpreting the findings and outcomes.

Role of advocacy organizations

Advocacy organizations have provided strong leadership in the children's mental health field, addressed the needs of youth and their families, ensured their rights, ensured that children received needed services, provided needed information and engaged in advocacy regarding family voice and involvement, research, early intervention and prevention, family support, education, community based services, and the importance of coordinated, integrated systems of care.

National organizations such as the Federation of Families for Children's Mental Health, the National Alliance for the Mentally Ill and the National Mental Health Association have ensured that children's mental health remains a highly visible, national priority. The Federation of Families for Children's Mental Health and the Center for Mental Health Services has supported the development of statewide family support networks run by family organizations in every state. Family organizations have provided education and training for youth, families and providers, advocated for interagency coordination and collaboration, provided peer-to-peer mentoring, support groups, youth groups, and individual advocacy. The family run organizations have been instrumental in increasing family involvement in their own treatment planning, increasing parent/professional collaboration, and in increasing effective family friendly policy development at the local, regional, state and national levels.

Recommendation 13. Significant attention should be paid to transitions between levels of care, services, agencies, or systems to ensure that care is appropriate, emphasizing continuity of care.

Youth with serious emotional and behavioral disorders in community systems of care are likely to receive services from multiple agencies and require different levels of care at different times. Consequently, they are likely to have many transitions, including shifting between treatment settings, responsible agencies, and service systems related to age. At such times, gaps in treatment, breaks in continuity of care, and inadequate service coordination are likely to arise. Examples of such transitions include youth turning 18 and transitioning from the child mental health system to the adult system, children or youth transitioning from the hospital or residential treatment to the community, children transitioning from day treatment to outpatient care, youth leaving juvenile justice correctional institutions, and young children transitioning from Early Intervention or early special education to school age.

The system of care should provide sufficient support for level of care intensity to be able to deliver each needed level of care (see Table 4). These levels of care should be comprised of different continuum of care components (see Table 2), augmented by whatever flexible wrap-around services are necessary to maintain the child the closest to their community but within the necessary level of care intensity.

There is a need for programmatic and financial support during these transitions. For example, in transitioning from residential treatment back to outpatient services, there may be a break in services before a new clinician is assigned. In such cases, the residential treatment center should provide services and care coordination during the transition period and be proactive prior to discharge in setting up the outpatient plan. Another example is a youth entering a juvenile justice setting who may be losing needed mental health services and important clinical information unless there is adequate communication and opportunity for mental health treatment in that setting. It is also important to involve the school in the planning process before a youth leaves a treatment center. In all cases the parents and youth should be involved in decision-making around these transitions in care.

The system of care should prioritize continuity of care whenever possible if the intervention is working, including situations in which funding considerations may mandate a switch of providers. This is especially true for primary health care providers in which continuous relationships have health benefits. During transitions, continuity should be maintained through communication and information transmission, ongoing coordination of care, and continuing a particularly effective service during the transition period. For example, some systems will allow a child to continue seeing a longstanding individual therapist periodically during placement in residential treatment to avoid an interruption in that relationship.

Recommendation 14. Systems of care should incorporate prevention strategies in clinical practice and system design.

Prevention is a core concept in the system-of-care philosophy. The integration of mental health services into schools, child welfare, and juvenile justice settings provides early intervention opportunities for children and youth with early symptoms of mental health disorders. A specific area for prevention whose importance is being increasingly recognized is the early childhood population. Since many agencies are involved with young children, the system-of-care model is very suitable for this age group. Surprisingly, systems of care have not been extended to the 0-5 age group until recently (Knitzer, 1998). There are substantial data demonstrating benefits of early intervention on later development (Shonkoff and Phillips, 2000). Examples of successful preventive approaches include nurse home visiting (Olds et al., 1998), referral of a young child to Early Intervention services, advocacy for stable placement (Goldstein et al., 1996), supporting prenatal care, provision of mental health services to parents (Lieberman and Zeanah, 1995), and early mental health services for children at risk for psychiatric disturbance (Webster-Stratton et al., 2004).

Systems of care bear responsibility to assign some of their resources to prevention efforts. These may include such activities as providing mental health consultation to Head Start, Early Intervention, and other childcare settings; providing mental health services to adults whose children are at risk of out-of-home placement; and providing consultation to primary care settings. For mental health agencies to provide services to children who do not yet meet the full criteria for a mental health diagnosis, the state and local funding agencies need to adopt alternative eligibility criteria for services or have contractual agreements with other child-serving agencies that obviate the need for formal diagnosis. For young children who are already showing some early symptoms of disorder, use of the more age-appropriate Diagnostic System for Zero to Three (DC:0-3) (Zero to Three, 1994) is more likely to identify conditions making them eligible for services.

Clinicians can incorporate prevention efforts in their clinical practice through helping to identify vulnerable or at-risk young children (as well as older children and adolescents) that might benefit from preventive services. Examples of vulnerable populations include children experiencing violence or other trauma and children showing signs of depression or other mental health problems in the school setting. Clinical preventive efforts include addressing parent mental health issues and working closely with other providers such as primary care practitioners, child care providers, schools, and community health nurses. Clinicians should advocate in their system of care for appropriate resources to be assigned to prevention, including accommodations to allow eligibility for young at-risk children and enhanced interagency cooperation among the different child-serving agencies. Child and adolescent psychiatrists can play a role in educating professionals from other systems who may be in a position to engage in early identification and referral.

Scientific Data and Clinical Consensus

Best practice guidelines are strategies for patient management, developed to assist clinicians in psychiatric decision-making. These best practices Tennessee Best Practice Guidelines for Child Behavioral Health are based on evaluation of the scientific literature and relevant clinical consensus, and describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. These guidelines are not intended to define the standard of care; nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all the circumstances presented by the patient and his/her family, the diagnostic and treatment options available, and available resources.

Table 1: Key Components of Community-Based SOC's

Interdisciplinary teams	Flexible services and dollars
Child & Family Teams	Array of community-based services
Case management	Evidence-based interventions
Wrap-around approach to services	Use of natural community supports to enhance
Family and youth advocacy	strengths
	Focus on function over diagnosis

Table 2: Continuum of Child Mental Health Services

Crisis/observation beds	Partial hospital/day programs
Intensive outpatient care	Therapeutic group homes
Respite services	Mobile emergency services
Home-based services	Acute inpatient care
Acute residential treatment	Outpatient crisis stabilization
Outpatient clinic/services	Residential treatment
School-based services	Rehabilitative services
Therapeutic homes	

Table 3: Evidence-Based Community-Based Interventions

Intensive Case Management	Mentor services
Wraparound Services	Family psychoeducation
Therapeutic Foster Care	Over 100 studies demonstrate improvement in:
Multi-systemic Therapy	Externalizing, internalizing, family function, reduced
Partial hospitalization	restrictive services (inpatient, residential, emergency
Mobile Crisis Services	room visits, etc.)

Table 4: Levels of Care in Systems of Care (from CASII)

Level 0: Basic Services	This is a basic package of prevention and health maintenance services that are assumed to be available to all people in the community
Level 1: Recovery Maintenance and Health Management	This level of service is usually reserved for those stepping down from higher levels of care that need minimal system involvement to maintain their current level of function or need brief intervention to return to their previous level of functioning. Examples of this level of service are: children or adolescents who only need ongoing medication services for a chronic condition or brief crisis counseling.

Table 4: Levels of Care in Systems of Care (from CASII continued)

Level 2: Outpatient Services	This level of care most closely resembles traditional once a week visits.
Level 3: Intensive Outpatient Services	This level of service can range from a couple visits per week up to a few hours for three days per week and may include multiple services (e.g., big brother, church services, mental health services) necessitating coordination (case management).
Level 4: Intensive Integrated Service Without 24-Hour Medical Monitoring	This level of care best describes the increased intensity of services necessary for the "multi-system, multi-problem" child or adolescent requiring more extensive collaboration between the increased number of providers and agencies. A more elaborate Wraparound plan is also required, using an increased number of formal supports. Additional supports may include respite, homemaking services or paid mentors. In more traditional systems, this level of service is often provided in a day treatment or partial hospitalization setting. Active case management is essential at this level of care.
Level 5: Non-Secure, 24-Hour, Medically Monitored Services	Traditionally, this level of care has provided a safe residence and has including group home, foster care or a residential facility, but can also be provided by a tightly knit array of Wraparound services in the community.
Level 6: Secure, 24-Hours, Medically Managed Services	Most commonly, these services are provided in inpatient psychiatric settings or highly programmed residential facilities. If security needs can be met through the wraparound process, then this level of intensity of service could also be provided in a community setting. Case management remains essential to make sure that the time each child spends at this level of care is held to the minimum required for optimal care and that the transition to lower levels of care are smooth.

Brief History

National

Community child mental health has a long tradition dating back to the Child Guidance movement of the early 1900s. Despite a resurgence of interest in community mental health beginning with the Community Mental Health Centers Act of 1964, community-based services for children failed to materialize (Lourie, 2003). In 1969 the Joint Commission on Children's Mental Health (1969) found that too many children were receiving grossly inadequate and inappropriate mental health services. A study published by the Children's Defense Fund, *Unclaimed Children* (Knitzer, 1982), further documented that children with serious mental and emotional disorders were receiving care that was fragmented, uncoordinated, and largely ineffective, often in institutions far from their homes. These findings led to the establishment in 1984 of the Child and Adolescent Service System Program (CASSP) under the auspices of the National Institute of Mental Health.

CASSP promoted the development of service delivery through a system-of-care approach, defined as a comprehensive spectrum of mental health and other services and supports organized into a coordinated

network to meet the diverse and changing needs of children and adolescents with severe emotional disorders and their families (Stroul and Friedman, 1986). CASSP outlined core values and guiding principles for a system of care that have served as a template for child community mental health system development across the nation. The major emphases of the CASSP principles are (1) individualized care that is tailored to the individual needs and preferences of the child and family, (2) family inclusion at every level of the clinical process and system development, (3) collaboration between different child-serving agencies and integration of services across agencies, (4) provision of culturally competent services, and (5) serving youth in their communities, or the least restrictive setting that meets their clinical needs. Community-based supports (e.g., respite, crisis shelter care, mentoring) are added to enable highly disturbed youth to remain with their families.

The SOC model for children's mental health required a change in service design and delivery. Several early demonstration projects were initiated to develop systems of care, including those in Ventura County in California (Attkisson et al., 1997) and Vermont (Bruns et al., 1995) and the continuum of care established by the Department of Defense CHAMPUS program at Fort Bragg, North Carolina. From 1990-1995 the Robert Wood Johnson Mental Health Services Program for Youth funded seven national demonstration programs. More recently, the Center for Mental Health Services (CMHS) Comprehensive Community Mental Health Services for Children and Their Families Program has funded more than 80 demonstration projects in diverse communities throughout the nation to implement systems of care. The goals of these programs have been to implement CASSP values, reduce out-of-home placements, reduce service fragmentation, and promote earlier mental health intervention to reduce functional morbidity. The goal of maintaining children in their communities has more recently been reinforced by rising mental health care costs, with the resulting priority of reducing utilization of highly restrictive and expensive services.

Although in the Fort Bragg study a randomly assigned system-of-care group showed clinical and functional outcomes similar to those of the traditional services group (Bickman et al., 1997), other system-of-care research has been more encouraging. A longitudinal study of the Vermont system of care concluded that the model was cost-effective and resulted in reduced rates of out-of-home placement (Santarcangelo et al., 1998). Outcomes of systems of care in three California counties were compared with those in three counties that had more traditional services. More positive outcomes were found in the system-of-care counties in the form of cost savings from reduced group home and foster care expenditures (Attkisson et al., 1997). Rosenblatt (1998) reviewed results of 20 community-based system-of-care studies, concluding that there were improvements in most domains assessed, including clinical status, cost, and use of restrictive placements. The system-of-care model appears to be beneficial for youth with severe emotional and behavioral disorders who are served in multiple systems and are at risk of being placed in restrictive settings.

Whereas child and adolescent psychiatry occupied a central role in the early community-oriented child guidance centers, later there was a shift to individual psychodynamic psychotherapy. Child and adolescent psychiatry has more recently reengaged itself as a discipline in community systems of care, providing an opportunity for a broader scope of child psychiatric practice. The current challenge facing child and adolescent psychiatry is to integrate its developing clinical and scientific knowledge and skills base into those systems and to integrate CASSP system-of-care values into the practice of child and adolescent psychiatry (Pumariega et al, 2003).

In 2003, the *President's New Freedom Commission on Mental Health* issued its report on transforming mental health care in America, reinforcing such SOC principles as family and youth partnerships,

cultural and linguistic competence, individualized services, and early intervention. The report also introduced the application of a public health approach to children's systems of care. Also during this time, the federal Children's Bureau funded nine states and local communities to build systems of care for children, youth, and families involved in the child welfare system. The bureau has continued to fund state and local communities in building or expanding systems of care for children with severe persistent mental illness. Five years later, the bureau funded regional technical assistance centers to work intensively with states to reform child welfare systems through the application of SOC concepts.

Over time, system of care efforts have broadened to encompass not only children with serious emotional disorders, as originally envisioned by CASSP, but also other populations of children, youth, and families involved, or at risk for involvement, in multiple systems. The system of care concept has been increasingly embraced, not only by the children's mental health field, initiating the movement, but also by other systems, such as child welfare and adolescent substance abuse treatment, with national support from federal agencies and foundations.

State

The Tennessee Department of Mental Health and Substance Abuse Services has had substantial experience with development and implementation of federally funded System of Care grants including securing the required federal match of cash and in-kind resources, using the SOC core values and guiding principles to guide the initiative. Tennessee's experiences are summarized in the table below. Federally funded System of Care grants are typically awarded for a six-year grant cycle with the possibility of a seventh year no-cost extension if funding allows. The first full year of the grant cycle is considered a planning year for the Initiative to organize, hire and train staff, develop the local governance structure, etc. Typically sites do not begin serving children until well into the second year of funding. The federal expectation and understanding of the importance of system and sustainability planning and development for the demonstration sites also has relevance to the Council on Children's Mental Health efforts for System of Care across Tennessee (discussed in the next section).

SAMHSA-funded SOC grants require children and families served with federal dollars to meet the following eligibility criteria: 1) child/youth at-risk of placement to a higher level of care such as inpatient hospitalization, residential placement, or state custody; 2) child/youth with serious emotional disturbance (SED); 3) child/youth who have multiple system involvement; 4) caregivers willing to participate in child's service delivery team; and 5) child/youth lives within defined geographic areas served by the grant (i.e. specific county). Families are usually at or near the federal poverty level. The initiatives are structured to be replicated and sustainable with outcomes measured by SOC national and local evaluations. A common staffing model for Tennessee's SOC initiatives is also present in each system where a child and family are served by a community liaison/mental health specialist and a family support provider. Typically, the family support provider is a parent or caregiver of a child with a mental health disorder who has successfully navigated multiple child-serving systems (i.e. mental health, child welfare, juvenile justice) and has been trained and/or certified as a Family Support Specialist by TDMHSAS.

| PROJECT | STATUS | CHILDREN/FAMILIES* SERVED | | SELECTED OUTCOMES |
		# SVD	SELECTED CHARACTERISTICS	
NASHVILLE CONNECTION Funding over 7 Years: $6.3M Federal $4.2 Match Provided**	Initiated: 1999 Ended: 2007	323	• Davidson County residents; • Children with SED age 5-18; • Global Assessment Function (GAF) of ≤ 50; • Multi-agency involvement; • Imminent risk of state custody or psychiatric hospitalization; • Most (69%) at or near poverty level; • One third w/ 4 or more family risk factors; • 40% of children w/ 2 diagnoses and 15% w/ 3 or more diagnoses; • 30% had previous psychiatric hospitalizations; • 50% of caregivers had mental illness or dual diagnosis.	• 97% of children remained in the community; • All demonstrated clinical improvement over time; • Decreased school absenteeism; • Decreased residential care and hospitalization; • Increased service coordination; • Improved grades; • Decreased suspensions; • When grant ended: (1) sustained and expanded MH-School Liaisons to rural East, Middle and West Tennessee through DMHSAS partnership with DOE; (2) sustained a piloted family support SOC-based program, "Family Connection" through DCS funding, local and state grants and single case agreements with MCOs.

* For purposes of this Table, the term "Families" is inclusive of caregivers with whom children/youth reside in a family setting.

** Match can be in the form of cash or in-kind contributions. Most match has been in-kind and much of it from the community.

^ Clinical Outcomes vary for each System of Care Initiative. Examples of these types of outcomes include: increased stability of living arrangements; decreased school suspensions, decreased delinquent behaviors; decreased use of marijuana; and improvement in measures relating to anxiety, depression, internalized and externalized behavior problems.

| PROJECT | STATUS | CHILDREN/FAMILIES* SERVED | | SELECTED OUTCOMES |
		# SVD	SELECTED CHARACTERISTICS	
Mule Town Family Network (now known as South Central System of Care (SCSC)) Funding Over 6 Years: $6.7M Federal $6.7M Match Required**	Initiated: 2005 Anticipated End Date: 2012	Target: 440 Served to Date: 414	• Maury County residents (under SCSC is now expanded to 12 counties that make up South Central DCS Region); • Birth-21 years of age; • SED diagnosis (includes but not limited to ADHD, OCD, bipolar, depression); • Multi-agency involvement; • 72% below poverty and 10% at or near poverty; • 44% have IEP; • 49% have witnessed domestic violence; • 66% have lived with someone who was depressed; • 13% have attempted suicide; • 70% of caregivers report a family history of depression; • 62% of caregivers report a family history of substance abuse.	• Increased stability of living arrangements; • Decreased school suspensions; • Decreased delinquent behaviors; • Improvement in measures relating to anxiety, depression, internalized and externalized behavior problems; • Reduced overall caregiver strain; • Increased behavioral and emotional strengths; • Over 95% of families reported positive experience on access to services, participation in treatment, cultural sensitivity, and satisfaction with services at both 6 and 12 month follow up.

* For purposes of this Table, the term "Families" is inclusive of caregivers with whom children/youth reside in a family setting.

** Match can be in the form of cash or in-kind contributions. Most match has been in-kind and much of it from the community.

^ Clinical Outcomes vary for each System of Care Initiative. Examples of these types of outcomes include: increased stability of living arrangements; decreased school suspensions, decreased delinquent behaviors; decreased use of marijuana; and improvement in measures relating to anxiety, depression, internalized and externalized behavior problems.

| PROJECT | STATUS | CHILDREN/FAMILIES* SERVED | | SELECTED OUTCOMES |
		# SVD	SELECTED CHARACTERISTICS	
Just Care Family Network Funding Over 6 Years: $9M Federal $8.5M Match Required**	Awarded: 10/2008 Anticipated End Date: 2014	Target: 450 Served to Date: 95 youth , 140 family members	• Shelby County residents; • 5-19 years old at time of enrollment; • Emotional, behavioral or mental health disorder present; • Multi-agency involvement; • At risk of placement outside home; • Caregiver/parent willing to maintain child in home, school and community.	• Increased natural supports for enrolled youth and families • Increased creation of and compliance with IEPs/504s • Decreased school suspensions • Decreased delinquent behaviors • Increased compliance with mental health treatment recommendations Projected outcomes in addition to improved Functional and Clinical Outcomes noted above: • Family Support Provider/Mental Health Consultant working as a team integral to SOC success in Shelby County • Youth That Care Youth Council and Parents That Care Support Group now established as vehicles for youth and family members to serve as community leaders & advocates for promoting awareness of and need to destigmatize mental health issues • Formal referral and collaborative care relationship with DCS, Juvenile Court and school system • Creation of county-wide child and family serving system that utilizes the wraparound approach to service delivery

* For purposes of this Table, the term "Families" is inclusive of caregivers with whom children/youth reside in a family setting.

** Match can be in the form of cash or in-kind contributions. Most match has been in-kind and much of it from the community.

^ Clinical Outcomes vary for each System of Care Initiative. Examples of these types of outcomes include: increased stability of living arrangements; decreased school suspensions, decreased delinquent behaviors; decreased use of marijuana; and improvement in measures relating to anxiety, depression, internalized and externalized behavior problems.

PROJECT	STATUS	CHILDREN/FAMILIES* SERVED		SELECTED OUTCOMES
		# SVD	SELECTED CHARACTERISTICS	
K-Town Youth Empowerment Network Funding Over 6 Years: $9M Federal $8.5M Match Required**	Awarded: 9/2009 Anticipated End Date: 2015	Target: 400 Served to Date: 95	• Knox County residents; • Youth age 14-21; • Emotional, behavioral or mental health disorder present; • Multi-agency involvement; • At risk of placement to a higher level of care (inpatient hospitalization, residential treatment, or state's custody); • Caregiver/parent willing to maintain child in home, school and community OR youth willing to participate in WRAP services to remain independently in the community.	PROJECTED Outcomes in addition to improved Clinical Outcomes^: • Youth In Action Council established as community leaders and peer advocates; • Improved functioning in the home, school, and community; • Successful transition into adulthood, per individual youth's definition.
Early Connections Network: Fulfilling the Promise Funding Request Over 6 Years: $9M Federal $8.5M Match Required**	Awarded: 10/2010 Anticipated End Date: 2016	Target: 400 Enrollment Opens July 2012	• Residents of Cheatham, Dickson, Montgomery, Robertson, and Sumner Counties; • Young children ages 0-5 and their families; • Emotional, behavioral or mental health disorder present or at risk of being developed; • A parent or caregiver willing to participate in the wraparound process to maintain the child at home, at school or childcare and in the community.	PROJECTED Outcomes in addition to improved Clinical Outcomes^: • Improved functioning in the home, pre-school, child care and community settings; • Expanded early childhood training of local community service providers • Increased number of early childhood specialists

* For purposes of this Table, the term "Families" is inclusive of caregivers with whom children/youth reside in a family setting.

** Match can be in the form of cash or in-kind contributions. Most match has been in-kind and much of it from the community.

^ Clinical Outcomes vary for each System of Care Initiative. Examples of these types of outcomes include: increased stability of living arrangements; decreased school suspensions, decreased delinquent behaviors; decreased use of marijuana; and improvement in measures relating to anxiety, depression, internalized and externalized behavior problems.

Council on Children's Mental Health

In 2008, Public Chapter 1062 (codified at T.C.A. 37-3-110 – 37-3-115) established the Council on Children's Mental Health (CCMH) to design a plan for a statewide system of mental health care for children. The principles for systems of care were promulgated in Title 33, the Mental Health and Developmental Disabilities law, in 2000. However, children's mental health issues span across departmental lines at the state and local levels. The significance of P.C. 1062 is its recognition that attaining children's mental health goes beyond administrative and service boundaries of any one department or agency.

The statue currently requires Council to develop a plan for a statewide system of care where children's mental health services is child-centered, family-driven, and culturally and linguistically competent, and provides a coordinated system of care for children's mental health needs in the state. The Council is to be co-chaired by the Commissioner of the Department of Mental Health and Substance Abuse Services and the Executive Director of the Tennessee Commission on Children and Youth. Council Members must include but are not limited to:

- Commissioners or designees of the Department of Children's Services, Finance and Administration, Health, Human Services, Education, TennCare Bureau, Intellectual and Developmental Disabilities, Mental Health and Substance Abuse Services (representatives familiar with children and youth services and alcohol and drug abuse services);
- Commission on Children and Youth Chairman or designee;
- Member of Governor's staff;
- Senator;
- Representative;
- Comptroller of the Treasury representative;
- Four parents of children who have received mental health services;
- Two persons under 24 years of age who are receiving or have received mental health services;
- Three representatives of Community Services Agencies;
- Two representatives of a statewide agency that advocates for children's mental health needs;
- Two representatives of providers of children's mental health services; and
- Three juvenile court judges, one from each grand division.

The plan should also include a core set of services and supports that appropriately and effectively address the mental health needs of children and families. The Council must develop a financial resource map and cost analysis of all federal and state funded programs for children's mental health, updated on an annual basis, to guide and support the plan. Other duties include stimulating more effective use of resources, assisting in developing interagency agreements, determining whether programs are evidence-based, research-based and theory-based and submitting those findings.
The Council is currently designing this prescribed plan by meeting every other month and relying on the help of various workgroups. Additional information or to become involved with the Council's work visit: http://www.tn.gov/tccy/ccmh-home.shtml.

References

American Academy of Child and Adolescent Psychiatry (AACAP). (1996a). *Best principles for managed Medicaid RFPs.* Washington, DC: Author.

American Academy of Child and Adolescent Psychiatry (AACAP). (1989). Policy statement on inpatient treatment of children and adolescents. Retrieved from http://www.aacap.org/publications.

American Academy of Child and Adolescent Psychiatry (AACAP). (1996b). *Guidelines for training towards community-based systems of care for children with serious emotional disorders.* Washington, DC: Author.

American Academy of Child and Adolescent Psychiatry (AACAP). (1998). *Best principles for measuring outcomes in managed Medicaid mental health programs*. Washington, DC: Author.

American Academy of Child and Adolescent Psychiatry (AACAP). (2004). *Child and Adolescent Service Intensity Instrument.* Washington, DC: Author.

American Academy of Child and Adolescent Psychiatry (AACAP). (2007). Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*.

Attkisson, C., Rosenblatt, A.B., Dresser, K.L., Baize, H.R., Clausen, J.M., Lind, S.L. (1997). Effectiveness of the California system of care model for children and youth with severe emotional disorders. In C.T. Nixon and C.A. Northrup (Eds.), *Evaluating Mental Health Services: How Do Programs for Children Work in the Real World?* (146-208). Thousand Oaks, CA: Sage.

Bickman, L., Summerfelt, W.T., & Noser, K. (1997). Comparative outcomes of emotionally disturbed children and adolescents in a system of services and usual care. *Psychiatry Services, 48,* 1543-1548.

Bronfenbrenner, U. (1979). *The Ecology of Human Development.* Cambridge, MA: Harvard University Press.

Bruns, E.J., Burchard, J.D., Yoe, J.T. (1995). Evaluating the Vermont system of care: Outcomes associated with community-based wraparound services. *Journal of Child Family Studies, 4*, 321-339.

Burns, B.J., Hoagwood, K. (2002). *Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders.* New York: Oxford University Press.

Burchard, J.D., Bruns, J.D., Burchard, S.N. (2002). The wraparound approach. In B.J. Burns & K. Hoagwood (Eds.), *Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders.* New York: Oxford University Press.

Costello, E.J., Angold, A., Burns, B.J., Erkanli, A., Stangl, D.K., & Tweed, D.L. (1996). The Great Smoky Mountain study of youth: Functional impairment and serious emotional disturbance. *Archives of General Psychiatry, 54*, 1137-1143.

Duchnowski, A., Kutash, K., & Friedman, R. (2002). Community-based interventions in a system of care and outcomes framework. In B.J. Burns and K. Hoagwood (Eds.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders.*

Friesen, B.J. & Stephens, B. (1998). Expanding family roles in the system of care: Research and practice. In; M.H. Epstein, K. Kutash, & A. Duchnowski (Eds.), *Outcomes for children and youth with behavioral and emotional disorders and their families: Program and evaluation best practices,* (pp. 231-259). Austin, TX: Pro-Ed.

Friesen, B.J. &Winters, N.C. (2003). The role of outcomes in systems of care: quality improvement and program evaluation. In A.J. Pumariega & N.C. Winters (Eds.), *Handbook of community-based systems of care: The new child and adolescent community psychiatry.* New York: Jossey Bass.

Goldstein, J., Solnit, A., Goldstein, S., & Freud, A. (1996). *The best interests of the child: the least detrimental alternative.* New York: Free Press.

Heffron, W.M., Pumariega, A.J., Fallon, T., & Carter, D.R. (2003). Youth in the juvenile justice system. In A.J. Pumariega & N.C. Winters (Eds.), *Handbook of community-based systems of care: The new child and adolescent community psychiatry.* New York: Jossey Bass.

Henggeler, S.W., Rowland, M.D., Halliday-Boykins, C., Sheidow, A.J., Ward, D.M., & Randall, J., et al. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in crisis. *Journal of American Academy of Child & Adolescent Psychiatry, 42*, 543-551.

Henggeler, S.W., Schoenwald, S.K., Rowland, M.D., & Cunningham, P.B. (2001). *Multisystemic treatment of children and adolescents with serious emotional disturbance.* New York: Guilford Press.

Hoagwood, K., Burns, B.J., Kiser, L., Ringeisen, H., & Schoenwald, S.K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52,* 1179-1189.

Hoagwood, K,, Jensen, P.S., Petti, T., & Burns, B.J. (1996). Outcomes of mental health care for children and adolescents: I. A comprehensive conceptual model. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*(8), 1055-1063.

Hodges, K. (1998 revision). *Child and Adolescent Assessment Scale.* Ypsilanti: Eastern Michigan State University, Department of Psychology.

Joint Commission on the Mental Health of Children. (1969). *Crisis in Child Mental Health: Challenge for the 1970s.* New York: Harper and Row.

Kamradt, B. & Meyers, M.J. (1999)., Curbing violence in juvenile offenders with serious emotional and mental health needs: The effective utilization of wraparound approaches in an American urban setting. *International Journal of Adolescent Medical Health, 11*, 381-399.

Knitzer, J. (1982). *Unclaimed children.* Washington, DC: Children's Defense Fund.

Knitzer, J. (1998). Early childhood mental health services: A policy and systems development perspective. In J.P. Shonkoff & S.J. Meisels (Eds.), *Handbook of early childhood intervention.* New York: Cambridge University Press.

Lieberman, A.F. & Zeanah, C.H. (1995). Disorders of attachment in infancy. *Child & Adolescent Psychiatric Clinics of North America, 4*, 574-587.

Lourie, I. (2003). A history of community child mental health. In A.J. Pumariega & N.C. Winters (Eds.), *Handbook of community-based systems of care: The new child and adolescent community psychiatry.* New York: Jossey Bass.

Lyons, J.S., Griffin, E., Fazio, M., & Lyons, M.B. (1999). *Child and Adolescent Needs and Strengths: An information integration tool for children and adolescents with mental health challenges (CANS-MH), Manual.* Chicago IL: Buddin Praed Foundation.

Mattison, R.E., Morales, J., & Bauer, M.A. (1993). Adolescent schoolboys in SED classes: implications for child psychiatry. *Journal of the American Academy of Child & Adolescent Psychiatry, 32*,1223-1228.

McClellan, J.M. & Werry, J.S. (2003). Evidence-based treatments in child and adolescent psychiatry: An inventory. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*,1388-1400.

Olds, D.L., Pettitt, L.M., Robinson, J., Henderson, C. Jr., Eckenrode, J., & Kitzman, H., et al. (1998). Reducing the risks for antisocial behavior with a program of prenatal and early childhood home visitation. *Journal of Community Psychology, 26,* 65-83.

Osher, T.W., deFur, E., Nava, C., Spencer, S., &Toth-Dennis, D. (1999). New roles for families in system of care. *Systems of care: Promising practices in children's mental health, 1998 Series, Volume I.* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Pires, S. A. (2010). *Building systems of care: A primer* (2nd ed.). Washington , DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

Porter, G.K., Pearson, G.T., Keenan, S., & Duval-Harvey, J. (2003). School-based mental health services: a necessity, not a luxury. In A.J. Pumariega and N.C. Winters (Eds.), *Handbook of community-based systems of care: The new child and adolescent community psychiatry.* New York: Jossey Bass.

Pumariega, A.J. & Fallon, T. (2003). Pharmacotherapy in systems of care for children's mental health. In A.J. Pumariega and N.C. Winters (Eds.), *Handbook of community-based systems of care: The new child and adolescent community psychiatry.* New York: Jossey Bass.

Pumariega, A.J. (2003). Cultural competence in systems of care for children's mental health. In A.J. Pumariega and N.C. Winters (Eds.), *Handbook of community-based systems of care: The new child and adolescent community psychiatry.* New York: Jossey Bass.

Pumariega, A.J. & Winters, N.C/ (2003a). *Handbook of community-based systems of care: The new child and adolescent community psychiatry.* New York: Jossey Bass.

Pumariega, A.J. & Winters, N.C. (2003b). Trends and shifting ecologies: part II. *Child & Adolescent Psychiatric Clinics of North America, 12*, 779-793.

Pumariega, A.J., Winters, N.C., & Huffine, C. (2003). The evolution of systems of care for children's mental health: Forty years of community child and adolescent psychiatry. *Community Mental Health Journal, 39*(5), 399-425.

Robins, D., Fein, D., Barton, M, & Green, J. (2001). The modified checklist for autism in toddlers: An initial study investigating the early detection of autism and pervasive developmental disorders. *Journal of Autism and Developmental Disorders*, *35*(2), 131-144.

Rogers, K. (2003). Evidence-based community-based interventions. In A.J. Pumariega and N.C. Winters (Eds.), *Handbook of community-based systems of care: The new child and adolescent community psychiatry.* New York: Jossey Bass.

Rosenblatt, A. (1998). Assessing the child and family outcomes of systems of care for youth with severe emotional and behavioral disturbance. In M.H. Epstein, K. Kutash, and A.J. Duchnowski (Eds.), *Outcomes for children and youth with behavioral and emotional disorders and their families: Programs and evaluation best practices* (pp.55-80). Austin, TX: Pro-Ed.

Rosenblatt, A., Wyman, N., Kingdon, D., & Ichinose, C. (1998). Managing what you measure: creating outcome-driven systems of care for youth with serious emotional disturbances. *Journal of Behavioral Health Services & Research, 25*, 177-193.

Santarcangelo, S., Bruns, E.J., & Yoe, J.T. (1998). New directions: Evaluating Vermont's statewide model of individualized care.

Shonkoff, J. & Phillips, D. (2000). *From neurons to neighborhoods: The science of early childhood Development.* Washington, DC: National Academy Press, Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education, National Research Council and Institute of Medicine.

Solnit, A.J., Adnopoz, J., Saxe, L., Gardner, J., & Fallon, T. (1997). Evaluating systems of care for children: Utility of the clinical case conference. *American Journal of Orthopsychiatry, 67*, 554-567.

State of California. (1997). *Addendum for implementation plan for phase II consolidation of medical specialty mental health services-cultural competence plan requirement.* Sacramento, CA: Health Welfare Agency, Department of Mental Health.

Stroul, B.A. & Blau, G. M. (Eds.) (2008). *The system of care handbook: Transforming mental health services for children, youth, and families*. Baltimore, MD: Paul H. Brookes.

Stroul, B. & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (rev. ed.). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Child Mental Health.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services. (1999). *Cultural competence standards for managed mental health care services: Four underserved/ underrepresented racial/ethnic groups.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Administration, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services. (2001). *Youth violence: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

VanDenBerg, J.E. & Grealish, E.M. (1996). Individualized services and supports through the wraparound process: philosophy and procedures. *Journal of Child and Family Studies, 5*, 7-21.

Vander Stoep, A., Green, L., Jones, R.A., & Huffine, C. (2001). A family empowerment model of change. In M. Hernandez & S. Hodges (Eds.), *Developing outcome strategies in children's mental health.* Baltimore, MD: Brookes Publishing.

Webster-Stratton, C., Reid, M.J., & Hammond, M. (2004). Treating children with early-onset conduct problems: Intervention outcomes for parent, child, and teacher training. *Journal of Clinical Child & Adolescent Psychology, 33*, 105-124.

Winters, N.C., Marx, L.S., & Pumariega, A.J. (2003). Systems of care and managed care: Are they compatible? In A.J. Pumariega and N.C. Winters (Eds.), *Handbook of community-based systems of care: The new child and adolescent community psychiatry.* New York: Jossey Bass.

Wood, G.M. (2004). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems—6: Family involvement in managed care systems.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida.

Woolston, J., Berkowitz, S.J., Schaefer, M.C., & Adnopoz, J.A. (1998). Intensive, integrated, in-home psychiatric services: the catalyst to enhancing outpatient intervention. *Child & Adolescent Psychiatric Clinics of North America, 7*(3), 615-633.

Worthington, J.E., Hernandez, M., Friedman, B., & Uzzell, D. (2001). *Learning from families: Identifying service strategies for success. Systems of care: Promising practices in children's mental health, Volume II*. Tampa, FL: Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida.

Zero to Three: Diagnostic classification. (1994). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood.* Arlington, VA: Zero to Three/National Center for Clinical Infant Programs.

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