

**BEST PRINCIPLES
FOR
EARLY CHILDHOOD
SYSTEMS OF CARE**

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

October 2002

Approved by Council October 2002

American Academy of Child and Adolescent Psychiatry

3615 Wisconsin Avenue, NW

Washington, DC 20016

©2002 American Academy of Child and Adolescent Psychiatry

TABLE OF CONTENTS

AUTHORS AND ACKNOWLEDGEMENTS

SECTION I.

INTRODUCTION

CORE VALUES FOR AN EARLY CHILDHOOD SYSTEM OF CARE

CURRENT ORGANIZATION OF SERVICES FOR EARLY CHILDHOOD

SECTION II.

DESCRIPTION OF AN EARLY CHILDHOOD SYSTEM OF CARE

I. PRIMARY, SECONDARY, AND TERTIARY PREVENTION

II. SCREENING/EARLY IDENTIFICATION OF RISK

III. ASSESSMENT

IV. INTERVENTIONS AND SERVICES

V. THE WRAPAROUND PROCESS AND CARE COORDINATION

VI. LEVELS OF CARE ACROSS SYSTEMS

VII. INTERAGENCY COORDINATION AND INTEGRATION

VIII. STAFFING AND TRAINING

IX. FINANCING AND BENEFIT DESIGN

X. GOVERNANCE

XI. ETHICS

XII. QUALITY IMPROVEMENT AND OUTCOMES MONITORING

XIII. INFORMATION SYSTEMS

CONCLUSIONS

APPENDIX A: CASSP CORE VALUES AND GUIDING PRINCIPLES

APPENDIX B: PRINCIPLES OF THE WRAPAROUND PROCESS

REFERENCES AND RESOURCES

AUTHORS AND ACKNOWLEDGEMENTS

This document was developed by the American Academy of Child and Adolescent Psychiatry's Work Group on Community-Based Systems of Care

Work Group on Community-Based Systems of Care

Mark Chenven, M.D., co-chair

Nancy C. Winters, M.D., co-chair

Andres Pumariega, M.D., past co-chair

Debbie Carter, M.D.

Theodore Fallon Jr., M.D., M.P.H.

Katherine Grimes, M.D.

William Heffron, M.D.

Robert Klaehn, M.D.

Larry Marx, M.D.

Kaye McGinty, M.D.

Kieran O'Malley, M.D.

Tom Vaughan, Jr., M.D.

Albert Zachik, M.D.

AACAP Staff Contact: Kristin Kroeger Ptakowski, Director, Clinical Affairs, 202-966-7300, ext 108

A special thank you to the following consultants and reviewers:

Charles Huffine, M.D.

Penelope Knapp, M.D.

Jan Martner, MSW

Barbara Brady, LCSW

Special Acknowledgement:

Jane Knitzer, Ed.D

Just as Knitzer's *Unclaimed Children* (1982) brought national attention to the inadequacy of mental health services for children and adolescents in the early 1980's, her work in the past decade has focused attention on the unmet mental health needs of infants, toddlers, and young children (1996; 1998; 2000). It is her leadership in this area that has led to the development of models of community-based service delivery for this age group nationwide. The authors acknowledge Dr. Knitzer's profound influence on the development of this monograph.

INTRODUCTION

This document focuses on developing a system of care for infants, toddlers and preschool aged children (ages 0-5), and their families; consideration of this age group also includes the prenatal period. Systems of care for young children differ from those targeting older youth in a number of ways. Different agencies and specialists are involved in early childhood services. These include primary care, prenatal, and perinatal specialists; child care, Head Start, and Early Intervention workers; developmental (occupational, speech/language, and physical) therapists; and child welfare workers. The 0-5 year-old population is the largest group of children in substitute care in the country. They are the most vulnerable medically, neurobiologically, psychologically, and socially. Young children, however, also have the most developmental plasticity and are the most likely to benefit from modest investments in protective and enriched environments, good relationships, and early prevention and intervention services.

In contrast to systems of care that have been developed to serve older children and adolescents, early childhood systems of care are grounded in a longstanding tradition of community-based care such as Early Intervention and home visitation. Early Intervention programs have a history of community-based practice dating from the early 1970's. The research has documented the benefits of pre- and post-natal home visitation by nurses in preventing the development of antisocial behavior in these children when they reach adolescence (Olds, 1993). The preventive power of home visitation can be enhanced by organizing other needed services around infants and their families through the integrated systems of care approach (American Academy of Child and Adolescent Psychiatry, 1997; Stroul and Friedman, 1986: Appendix A).

As systems of care have developed for older children, adolescents and their families, the principles of wraparound (VanDenBerg & Grealish, 1996; Appendix B) have proven to be powerful tools for the successful development of community-based treatment. Strength-based, individualized service planning and family empowerment and inclusion have become concepts essential to both wraparound and the successful implementation of systems of care. Although wraparound has only recently come into use in the 0-5 year age group, the wraparound philosophy is ideal for young children and their families.

The literature on developmental risks and protective factors has yielded insights that can be applied on a wider scale. Maternal depression, adolescent parenthood, marital conflict, family violence, parental substance abuse, and poverty are known environmental risk factors (Zeanah, 1997), while secure attachments, good prenatal care, establishment of long-term supportive relationships with adults, and early intervention to mediate factors that negatively influence development, can be protective factors. The recent book *From Neurons to Neighborhoods: The Science of Early Childhood Development* (National Research Council and Institute of Medicine, 2000) describes the current state of the science of early childhood development and integrates this knowledge into the clinical practice of early intervention.

One of the major roles for child and adolescent psychiatrists and other mental health professionals in an early childhood system of care is the application of state-of-the-art knowledge of child development and neuroscience to inform the treatment of infants, toddlers and their families in community settings. Mental health professionals are also trained in the biopsychosocial model, a comprehensive approach to formulation of emotional and behavioral problems integrating constitutional, developmental, family, and social factors; this model facilitates a comprehensive approach to assessment and treatment.

Accurate and comprehensive diagnostic assessment is essential to development of effective treatment plans and assists clinicians and families in communicating effectively about the child's challenges. The National Center for Infants, Toddlers and Families' development of the *Diagnostic Classification: Zero to Three* (1994) has been a significant advance in the psychiatric diagnosis of this age group. In addition to developing age appropriate criteria for the diagnosis of disorders such as anxiety and depression in children aged zero to three years, the *Diagnostic Classification: Zero to Three* (DC: 0-3) also introduced several new diagnostic categories: regulatory disorders and relationship disorders. The diagnosis of regulatory disorder, according to the DC:0-3 is made through the identification of behavioral disturbances "coupled with a sensory, sensory-motor, or organizational processing difficulty which affects the child's daily adaptation and interaction/relationships (Zero to Three, 1994). Relationship disorders identify maladaptive interactional patterns between the primary caregiver and child and are coded on Axis II of this diagnostic system. The DC:0-3 diagnostic system represents a significant advance. We recommend its use in early childhood systems of care.

Many elements must be brought together to form a mature system of care for the early childhood population. Focus on screening, prevention and early intervention delivered in community settings must continue and be strengthened by the use of the principles of wraparound and family-centered practice and the application of state of the art scientific and medical knowledge. Perhaps Selma Fraiberg said it best: "We...conceive of infant mental health as a province of community mental health which extends beyond the borders of any clinic or social agency" (1980). To best serve the next generation, we must identify those at risk, serve them early and serve them where they live.

CURRENT ORGANIZATION OF SERVICES FOR EARLY CHILDHOOD

How well does the current system of care for early childhood conform to what we know about the needs and vulnerabilities of young children and their families? Although there are many elements in the traditional early childhood service system, there are also many challenges. Sociocultural and historical factors have contributed to lack of a truly child-centered orientation for the agencies that serve the early childhood population such as prenatal health and child welfare. Early childhood services tend to be categorical and may not function as an integrated or coordinated system of care. For example, child health, (the primary service provider for young children) and mental health are generally organized in separate delivery systems. Early childhood services have the additional problem of temporal discontinuity. For example, Early Intervention programs serve children aged 0-3 years, while Head Start or Early Special Education serves 3-5 year-olds.

Availability of mental health services for young children and their families is limited. Physical health, childcare, and child welfare are the earliest service systems to become involved with young children and their families; mental health is generally the last. Availability is limited by lack of providers trained to work with this age group. Another problem is that the psychiatric diagnostic system (DSM IV) is minimally applicable to this age group. Young children not meeting full criteria for DSM IV diagnoses may be ineligible for mental health services. DC: 0-3 was developed specifically for infants and toddlers; it has several innovations for this age group, such as the new diagnoses of regulatory disorders and relationship disorders on Axis II.

Although more appropriate for the early childhood population, the DC:0-3 diagnostic system is not widely accepted for service eligibility or insurance reimbursement. However, the Health Insurance Portability and Accountability Act (HIPPA) data consistency provisions have spawned efforts to develop “crosswalks” between DC:0-3 and DSM-IV or ICD 9CM. Despite potential problems in conceptual compatibility, some crosswalks seem promising in enabling communities to pursue use of DC:0-3 in their early childhood system of care.

This monograph will identify core values and guiding principles for an early childhood system of care in Section I. Section II will identify the necessary elements in the organization and array of services within the early childhood system of care.

Section I.

CORE VALUES & GUIDING PRINCIPLES FOR EARLY CHILDHOOD SYSTEMS OF CARE

1) The system of care prioritizes the biological, cognitive, and socio-emotional development of the child.

The overriding goal of the early childhood system of care is to create an environment in which young children either at-risk for or having developmental delays or emotional disturbances can achieve optimal biological, psychological and social development. To use a metaphor from the writings of D.W. Winnicott (1965), the early childhood system of care must support the integrity and continuity of the young child's "holding environment". Though Winnicott's work primarily addresses the parent-child dyad, the concept of holding environment can be broadened to include the child and family's community and the early childhood system of care.

2) The system of care strives to strengthen and preserve the child's primary attachment and family relationships.

The role of attachment in brain development and in the development of cognition, emotional regulation, and interpersonal relationships has been well documented in the child development literature. In order to better support the attachment between infants and their parents (biological, adoptive, or foster) the early childhood system of care must strive to support infants and toddlers in their home of origin and minimize the number of placements if removal from the child's birth home becomes necessary. Preemptive use of the wraparound process may help stabilize infants and toddlers and help prevent subsequent placements.

3) The system of care emphasizes prevention and early intervention through timely screening, identification and delivery of services, to maximize the child's opportunities for normative development.

Current scientific research supports the belief that normal early development is the foundation upon which good social and emotional functioning in later childhood, adolescence, and adulthood is based. Thus, it is critical for providers in the system of care to screen and identify problems early and intervene quickly to avoid later developmental and emotional disturbance. Linkages between treatment sites and professionals of various disciplines must be strengthened so that transitions are smooth and risks can be treated without disruptions. The early childhood system of care must follow at-risk infants identified at birth and ensure that their developmental and mental health needs continue to be addressed as they move through the array of community providers. Young children whose life conditions pose risk of developmental, cognitive and emotional disturbance should be identified early for appropriate mental health intervention.

4) The system of care supports the stability of the child's family, whether biological, adoptive, or foster.

Recent research supports the notion that early environments are extremely

important in child development and that warm, supportive care giving is essential. Thus, an early childhood system of care must make the stability of families and community-based caregivers its highest priority. Nowhere is this more important than in the child welfare system, where the number of infants and toddlers in out-of-home care continues the increase. According to Goerge and Wulczyn (1998), a child under age 5 is twice as likely to be in foster care than older children or adolescents and is more likely not to be returned to his or her biological parents' care.

Continuity of care is another concern for early childhood systems of care. Young children with serious emotional disturbances or developmental delays are likely to have multiple childcare placements due to the lack of training in caring for children with special needs in many settings. More robust mental health consultation to community-based care providers may help give these children more stability in their childcare settings.

5) The system of care empowers families by making them full partners in the planning and delivery of services.

Infants and toddlers cannot advocate for their own needs. Thus, those persons who know them the best (their birth parents, grandparents, adoptive parents, foster parents, or others) must not only be a focus of services, but also must be engaged as full partners in developing service plans. Partnering facilitates the necessary individualization of care that is absolutely essential to the development of effective service plans, as, for example, the needs of a teen parent are vastly different than those of grandparents who become the primary caregivers for their grandchildren. Empowered parents are more likely to engage with and follow through with recommended services.

6) The system of care provides culturally competent services that respect the family's unique social and cultural values and beliefs.

Without close attention to the cultural values of the young child's family and community, the individualized service plan is likely to fail to serve the infant or toddler's needs effectively. Beliefs concerning most aspects of parenting will vary from culture to culture and providers within the early childhood system of care must understand and respect these differences for their work to be successful (Center for Mental Health Services, 2001).

7) The system of care supports the early identification of infants, young children and families at-risk and provides individualized service plans based on comprehensive biopsychosocial assessment.

Early identification of at-risk individuals should take place both in formal service arenas as well as in community-based settings such as childcare, preschool and neighborhoods. Similarly, a comprehensive assessment approaches the young child in the ecological context of his or her family and other care giving environments. This is best performed in naturalistic settings (e.g. home, child care settings) in which the child can be seen with his or her primary caregivers and other important people. Comprehensive assessments of young children identify areas of risk and vulnerability as well as strengths and potential protective factors that can be targets of strength-based interventions, i.e.,

services which build on the existing child's and family's skills and capabilities. Comprehensive assessment should address constitutional, cognitive, socio-emotional, and adaptive aspects of the child's development, the child's primary attachment relationships, the child's care giving environment (including parental mental health status), and the child's level of functioning in normative and/or therapeutic settings.

8) The system of care provides individualized services that are of appropriate intensity, flexibility, and comprehensiveness to meet the child and family's needs; these services should be integrated and coordinated between different child-caring agencies.

The individualized service plan must be adopted by all agencies in the early childhood system of care in order to avoid duplication of services and to ensure that all essential needs are met. Support for the family's needs cannot be neglected in their service plans if the young child is to be optimally supported toward normal development. This may include close coordination between the infant's providers and the caregiver's providers should the adult caregiver also require mental health services.

9) The early childhood system of care strives to have an ethical balance between protecting the rights of children and supporting the rights of parents.

Complex ethical issues are likely to arise in a system of care for young children. Difficult decisions regarding child custody and the termination of parental rights, for example, must be made at times without the consultation necessary to make an impartial decision that might be in the best interest of the both child and their family. Early childhood systems of care would benefit greatly from the creation of an Ethics Committee to help resolve complex issues involving multiple stakeholders in a just and balanced fashion.

SECTION II.

DESCRIPTION OF AN EARLY CHILDHOOD SYSTEM OF CARE

I. Primary, Secondary and Tertiary Prevention:

- Focuses on at-risk populations and ethno-cultural groups of children in the community.
- Provides public health education, including education on neuroprotective factors and teratogens.
- Provides screening tools and prevention resources for parents and childcare providers.
- Provides substance abuse treatment for parents before, during, and after pregnancy.
- Provides linkages to enhance access to prenatal care.
- Provides screening, assessment and treatment of mental health disorders in parent(s).
- Provides culturally competent parenting classes.
- Provides genetic counseling.

- Provides screening, treatment and supportive services for transgenerational abuse.
- Provides secondary prevention by addressing early risk factors or signs of difficulty to prevent development of a disorder, e.g. identification of developmental or socio-emotional delay.
- Provides tertiary prevention to limit impairment after a disorder develops by appropriately targeted interventions, e.g. placement in therapeutic or medical foster care, provision of developmental therapy services.

II. Screening/ Early Identification of Risk

- Clinicians screen children as early as possible- prenatal or at birth for high-risk births.
- Clinicians screen young children where they are most commonly seen, e.g. prenatal visits, mother-baby unit, childcare, primary care, hospital unit, home, foster home.
- Parents have access to core developmental expectations and to screening and assessment services including call-in and walk-in services.
- Clinicians have separate screening process to address the needs of high-risk children and those attending well baby/child visits.
- Culturally competent service providers screen children using culturally sensitive screening tools.
- Clinicians screen young children using the language the family uses or translators knowledgeable in child development and linguistic nuances of the language and customs described.
- Clinicians provide clinically and culturally relevant summaries of their findings.
- Clinicians work with the family and service providers to identify an integrated action plan for service referral.

III. Assessment

- Assessment is based on a biopsychosocial formulation that views the child in the ecological context of his or her family and other significant relationships.
- Comprehensive assessment of young children is likely to involve a greater number of contacts than for older children, as it is essential to see child with multiple caregivers to adequately assess their influences.
- Assessment is performed by individuals with specialized training with infants and young children. Skills include ability to perform physical and neurological examination, developmental assessment, assessment of significant relationships, and milieu-based assessment in the child's natural settings.
- Assessment is performed by clinicians who understand that culture, gender roles, family size, (i.e. nuclear vs. extended), multiple caregivers, and other environmental resiliency factors must be recognized.
- Useful resources include the AACAP *Practice Parameters for the Psychiatric Assessment of Infants and Toddlers* (0-36 months) (American Academy of Child and Adolescent Psychiatry, 1997) and the Infant Mental Status Exam (Benham, 2001).
- Diagnostic mental health assessments should utilize the current edition of

standardized DSM-IV system as applicable, however, use of DC:0-3, a specialized diagnostic system for early childhood disorders should be encouraged to supplement and refine the mental health assessment. As warranted, Early Childhood Systems of Care should authorize “cross-walking” between DC:0-3 and DSM-IV axes to facilitate uniform coding and appropriate reimbursement procedures.

IV. Interventions and Services

- Developmentally appropriate eligibility criteria for mental health services is adopted through endorsement of DC:0-3.
- Services should address the child in the ecological context of his or her family and primary attachment relationships.
- Families are empowered through fostering strengths, parenting skills, self-help and coping skills, and peer support.
- As a policy, the system should emphasize family preservation. If the child is removed from the family, the number of placements should be kept to a minimum.
- Services are available to address caregiver mental health needs and are coordinated with the child’s services.
- Clinical programs should offer culturally appropriate services.
- Services should be delivered in the most normative setting possible, and intensity of services should be increased without unnecessary disruption to the child’s environment or relationships.
- A “one-stop-shopping” model for delivery of services is used as much as possible, e.g. family drop-in centers.
- New developmental concepts are integrated into all interventions and programs are developmentally appropriate in design.
- Services should include the full range of interventions, including non-invasive psychosocial interventions, neurobiological remediation and psychopharmacology.
- Pharmacological treatments are generally not used until adequate psychosocial interventions have been tried.
- Clinicians are skilled in a variety of techniques, using evidence-based approaches as much as possible, and know when to refer for additional services.
- Clinicians must be aware of important ethical issues such as informed consent and confidentiality
- Clinicians should provide services for vulnerable families such as teen parents, families with a substance-abusing caretaker, parents with psychiatric disorders, and families experiencing domestic violence.
- Mental Health clinicians should be available to provide a full array of relevant mental health services, directly or through linkage to the following early childhood services:
 - ◊ Head Start programs,
 - ◊ Pediatric, preschool and general health care,
 - ◊ Vision and hearing screenings,

- ◇ Occupational and sensory integration therapies,
- ◇ Physical therapy,
- ◇ Speech and language therapy,
- ◇ Parenting classes,
- ◇ Developmental disability services,
- ◇ Home-based services,
- ◇ Child welfare agency and family courts.
- ◇ Other non-mental health service settings.
- ◇ Therapeutic nurseries,
- ◇ Daycare settings and more specialized therapeutic programs including therapeutic nurseries,
- ◇ Adult residential treatment (e.g. chemical dependency program) where the child can stay with the parent and the dyad receives treatment, and
- ◇ Mental health consultation to child welfare agency and family courts.

V. Care Coordination and the Wraparound Process (Appendix B)

- Family-centered care is a cornerstone of both wraparound and early childhood treatment. Wraparound philosophy recognizes that the needs of the child and family are constantly changing (in keeping with the essential nature of young children's rapid development). Wraparound is a strength-based approach, optimal for the preventive emphasis in the early childhood age group.
- The wraparound process is used to develop an appropriate Individualized Service Plan.
- Care coordination across agencies is available to ensure coordination and access to needed services. Family-centered care coordination is the vehicle for the wraparound process.
- An infant and toddler's needs are necessarily addressed by persons from various disciplines such as pediatrics, child psychiatry, child psychology, social work, education, and various community agencies that must all cooperate with each other.
- Wraparound's "no eject, no reject" policy allows for service continuity at a critical stage of children's development.
- Care coordinators should have adequate time and a small enough caseload to comprehensively address the young child's needs.
- Care coordinators should be familiar with different child-serving systems in order to negotiate these systems.
- Care coordinators should be advocates to help the community meet the child and family's needs.

VI. Levels of Care Across Systems

Level of care for this age group is not as often defined by setting or facility. It is tied to the child and family's needs, such as degree of protection or family support needed. Level of care for early childhood comprises the following elements:

- Timing, intensity, and duration of intervention,
- Comprehensiveness of intervention,

- Extent of child’s need for protection or containment,
- Intensity of work with parent and/or parent-child dyad,
- Involvement of multiple child-serving agencies,
- Need for specialized or professionally supported milieu-based setting.

VII. Interagency Coordination and Integration

- Interagency integration and coordination is a core characteristic of the system of care. Given the number of agencies responsible for this age group, the system of care represents a “knitting together” of their efforts without necessarily dissolving separate administrative structures.
- Mental health and non-mental health interventions are integrated in a coordinated service delivery system.
- System design maximizes seamless transition across child-caring agencies. This necessitates removal of artificial barriers to services such as those resulting from separate funding sources.
- Make available individualized services that match the child and family’s needs.

VIII. Staffing and Training

- Specialists should have smaller staff caseloads for services to children and their families due to the level of care and cross system linkages needed.
- There must be ongoing staffing and training of specialists to develop multiple skilled individuals and specialists who can integrate evidenced base interventions into treatment services.
- The availability of an array of interventionists at various levels of training including paraprofessionals, masters level trained staff on through doctoral and medically trained providers.
- Areas of training should include knowledge in basic child development, attachment, mental health and substance abuse, family functioning, cultural competency, child neglect/abuse information, health maintenance, educational needs, legal issues, and service eligibility criteria.
- Interagency and inter-professional collaboration are supported through organizational policy and cross-training between different disciplines.
- Adequate financial and time investment is made in the training and reimbursement of childcare workers and other providers of care to young children.

IX. Financing and Benefit Design

- The system of care benefit design must be flexible to allow the identified child and family to receive a wide range of services, including services addressing social needs.
- The availability of a pool of blended funds administered by an interagency administrative body and a care management system that allows for maximal flexibility.
- The allocation of financial resources in the system is proportional to the numbers, needs, and potential benefits of intervention in this age group.

- The needs of individual children are balanced against the financial resources available to the population.
- Funding should be available for support and respite services to families as well as direct services.
- Investment is made in research to fill knowledge gaps, including high quality research on outcomes of interventions.

X. Governance

- The system of care program governance should reflect a broad based membership drawn from the varied child serving groups.
- This multistakeholder governance body should have meaningful influence on programmatic and funding decisions.
- Governance should include significant family representation supported by an active parent advocacy organization when available.

XI. Ethics

- The system of care establishes an ethics committee to deal with difficult cases and other ethical dilemmas such as balancing fetal developmental needs with the parents' wishes or in situations where cultural issues could compete with the welfare of child, e.g. Native American law.
- Advocates for children are identified when biological or other caregivers are unable to adequately represent the needs of the child.
- Effective advocacy systems exist to ensure that the system of care addresses developmental needs of young children from the prenatal period through childhood.

XII. Quality Improvement and Outcomes Monitoring

- The system of care is accountable for outcomes that are identified by families and other stakeholders of the system, such as child-serving agencies and members of the community.
- Outcomes in the early childhood population are seen in a relational/environmental context; significance of the infant's behavior in the dyadic relationship is emphasized.
- Outcomes for the infant, parent, dyad, family, and community are considered and competing interests or needs are balanced.

XI. Informational Systems

- Informational systems are designed by an interagency body to provide information needed to assess achievement of results identified as target outcomes for the system.
- Information should include functional, developmental, and health status; relevant family information; and service use data.

CONCLUSIONS

Children aged 0-5 comprise a vulnerable population that is a public health concern. Early childhood systems of care encompass principles of primary, secondary and tertiary prevention in which mental health and other childhood specialists offer timely, developmentally appropriate services to young children. Recognizing that the interaction between nature and nurture is most prominent during this developmental period, an early childhood system of care has a family focus that is enhanced by use of the wraparound approach to service planning. Use of comprehensive biopsychosocial models, including best knowledge of brain and physical development, risk and resilience literature, and cultural factors impacting families, can enhance delivery of clinically appropriate interventions. Coordinating efforts of different agencies responsible for this age group requires organizational change at local and state levels to minimize barriers resulting from separate funding streams and administrative structures.

REFERENCES

- 1) American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th ed.)* Washington, DC
- 2) American Academy of Child and Adolescent Psychiatry (1997), Practice parameters for the psychiatric assessment of infants and toddlers (0-36 months). *J Am Acad Child Adolesc Psychiatry* 36 (10, Suppl.) 21S-34S
- 3) Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups (2001), *Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Dept Health and Human Services*
- 4) Zero to Three (1994), Diagnostic classification: 0-3. *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. Zero To Three: National Center for Infants, Toddlers, and Families*
- 5) Benham, AL (2001), The observation and assessment of young children including use of the infant-toddler mental status exam. In CH Zeanah (Ed.) *Handbook of Infant Mental Health*. New York: Guilford Press, 249-270
- 6) Fraiberg, S. (1980), *Clinical Studies in Infant Mental Health: The First Year of Life*. New York: Basic Books
- 7) Goerge, RM, Wulczyn, F. (1998/1999), Placement experiences of the youngest foster care population: Findings from the Multistate Foster Care Data Archive. *Bulletin of Zero to Three: National Center for Infants, Toddlers and Families*.

19:8-13

- 8) Knitzer U (1982), *Unclaimed Children*. Washington, DC: Children's Defense Fund
- 9) Knitzer J (1996), Meeting the mental health needs of young children and their families, in *Children's Mental Health: Creating Systems of Care in a Changing Society* Baltimore: Paul H. Brookes Publishing Company
- 10) Knitzer J (1998), Early childhood mental health services: A policy and systems development perspective, in Shonkoff JP & Meisels SJ (Eds.) *Handbook of Early Childhood Intervention* New York: Cambridge University Press
- 11) Knitzer J, Yoshikawa H, Cauthen NK, Aber JL (2000), Welfare reform, family support, and child development: perspectives from policy analysis and developmental psychopathology. *Dev Psychopathol* 12:619-632
- 12) National Research Council and Institute of Medicine (2000). *From Neurons To Neighborhoods: The Science of Early Childhood Development*. Committee on Integrating the Science of Early Childhood Development. Shonkoff, J.P. & Phillips, D.H., editors. Board on Children, Youth and Families, Commission on Behavioral and Social Sciences and Education. Washington, D.C.: National Academy Press
- 13) Olds DL, Kitzman H (1993), Review of research on home visiting for pregnant women and parents of young children. *The Future of Children* 3:53-92
- 14) Stroul, BA and Friedman, RM (1986) *A System of Care for Children and Youth with Severe Emotional Disturbances*. (Revised Edition) Washington, D.C.: CASSP Technical Assistance Center, Georgetown University Child Development Center
- 15) VanDenBerg J, Grealish E (1996), Individualized services and supports through the wraparound process: Philosophy and procedures. *Journal of Child and Family Studies*. 5:7-21
- 16) Winnicott DW (1965) *The Maturation Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*. New York: International Universities Press, Inc. (7th printing, 1982)
- 17) Zeanah CH (1997), Infant development and developmental risk: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatry* 36:165-178

APPENDIX A

CASSP CORE VALUES AND GUIDING PRINCIPLES

CORE VALUES AND GUIDING PRINCIPLES FOR AN EARLY CHILDHOOD SYSTEM OF CARE

Core Values

- 1) The system of care prioritizes the biological, cognitive, and socio-emotional development of the child.**
- 2) The system of care strives to strengthen and preserve the child's primary attachment and family relationships.**
- 3) The system of care emphasizes prevention and early intervention through timely delivery of services, to maximize the child's opportunities for normative development.**

Guiding Principles

- 4) The system of care empowers families by making them full partners in the planning and delivery of services.**
- 5) The system of care supports the stability of the child's family, whether biological, adoptive, or foster.**
- 6) The system of care provides culturally competent services that respect the family's unique social and cultural values and beliefs.**
- 7) The system of care provides individualized service plans based on comprehensive biopsychosocial assessment.**
- 8) The system of care provides individualized services that are of appropriate intensity, flexibility, and comprehensiveness to meet the child and family's needs; these services are integrated and coordinated between different child-caring agencies.**
- 9) The system of care strives for an ethical balance between protecting the rights of children and supporting the rights of parents.**

APPENDIX B

PRINCIPLES OF WRAPAROUND

The wraparound approach has become central to the system-of-care concept. Wraparound is a philosophy and approach, rather than a set of services. Central to this approach is the requirement that services be designed to fit the unique and specific needs of children and families. The wraparound process as described by VanDenBerg and Grealish (1996) includes the following elements:

- 1) Wraparound efforts are based in the community;
- 2) Services and supports are individualized to meet the needs of the children and families rather than being driven by priorities of categorical services;
- 3) Parents are included in every level of the planning process;
- 4) The process is culturally competent and based on unique values, strengths and social or racial composition of the child and family;
- 5) The process must have access to flexible, non-categorical funding;
- 6) The process must be implemented on an interagency basis and owned by the larger community;
- 7) The services must be unconditional, so that when needs change, the service are modified rather than the child or family being rejected;
- 8) Outcomes must be measured so that the process is developed on an empiric scientific basis.