

SYSTEMS-BASED PRACTICE OVERVIEW Revised August 2012

SYSTEMS-BASED PRACTICE: OVERVIEW OBJECTIVES*

Knowledge

The resident will demonstrate an adequate knowledge of:

- 1) The definition of systems-based practice. (1-12)
- 2) The Psychiatry Residency Review Committee systems-based practice competencies. (1-12)
- 3) The definition of a system. (1-4,7)
- 4) Child-serving systems in the United States. (1,2,4,5)
- 5) Multiple roles of a child and adolescent psychiatrist working with/in systems. (1-12)
- 6) Bronfenbrenner's ecological systems theory and its' implications for working with youth and families. (1-12)
- 7) Principles and importance of family-driven youth-guided care, cultural competence and evidence-based practice in provision of services. (1-12)
- 8) New "rules" for a 21st century health care system (per Institute of Medicine). (1-12)
- 9) Principles and goals in a transformed mental health system (per President's New Freedom Commission on Mental Health). (1-12)
- 10) Principles and practices for child mental health care in community systems of care (per the AACAP practice parameter). (1-12)

Skills

The resident will demonstrate the ability to:

- 1) Describe and use systems thinking. (1-12)
- 2) Practice family-driven care in a culturally competent manner. (1-11)
- 3) Coordinate care with families and service partners. (1-11)
- 4) Obtain and document information regarding systems involved during patient care encounters. (1,2,5)
- 5) Identify and work in a variety of roles with/in various child-serving systems. (1-12)
- 6) Assure quality of care issues by providing and/or advocating for evidence-based practice in patient care encounters. (5-12)

Attitude

The resident will demonstrate the commitment to:

- 1) Show evidence of an enhanced view of youth and families, including their strengths in your patient care encounters. (1-11)
- 2) Respect the importance of family-driven and youth-guided care. (1-11)
- 3) Appreciate the role of teams and value each member's contributions. (1-12)
- 4) Respect the importance of stakeholder inclusion. (1-12)
- 5) Respect the culture of the various child-serving systems. (1-12)
- 6) Appreciate the complexity of systems and strive to understand their multiple components. (1-12)

* Parentheses refer to systems-based practice competencies in the RRC Program Requirements.¹ See Appendix 1 for complete list of competencies.

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I. ADDRESSING THE NEED FOR SYSTEMS-BASED PRACTICE

The Accreditation Council for Graduate Medical Education (ACGME) has mandated that all Residency Review Committees (RRC) incorporate the six core competencies into their requirements to promote and demonstrate the competency of their graduating residents. In response, national organizations and training programs have become actively involved in developing a framework to define, implement and evaluate the general competencies. In the meantime, child services system-based practice in the U.S. has become more developed and important in the service delivery for youth and their families. Therefore, the AACAP Work Group on Community-Based Systems of Care has dedicated their efforts towards the goal of developing a training tool kit for systems-based practice for child and adolescent psychiatry residency programs. An Abramson Grant from AACAP was awarded to the Work Group in November 2006 to complete the development of the tool kit, pilot the tool kit in child and adolescent psychiatry residency programs, and to develop educational competency outcomes and a training director network.

A. ORGANIZATION OF THE TOOL KIT

The tool kit is organized into thirteen modules. Each module covers an important component of systems-based practice and contains learning objectives, core information in handout form, and vignettes. The objectives for each module are categorized based on the Psychiatry RRC specific systems-based practice competencies (see Appendix 1). The vignettes will be used for group discussion and for evaluating individual resident competency in systems-based practice. The systems-based practice knowledge base is interrelated and there will be some intentional repetition of information within the tool kit.

B. ACGME AND RRC STANDARDS

Systems-based practice is one of the six core competencies of medical practice, as defined by the ACGME. Systems-based practice refers to the physician’s awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.¹ Within child and adolescent psychiatry, this competency pays particular attention to the fact that child psychiatric care provided to the individual child is always embedded within the larger contexts of the child’s family, immediate community and larger culture and society.²

The Psychiatry RRC has approved specific competencies in systems-based practice (see Appendix 1 for complete list).

As child and adolescent psychiatrists (CAPs) we are practicing in various systems and working with other systems that are continually changing and evolving. Understanding the many child-serving systems will help you deliver more effective patient care and advocate for your patients and their families.

To help you learn more about systems-based practice, we present a review of systems, their foundation principles, the history of child mental health services and recent developments in medicine and government policy that affect clinical practice.

II. SYSTEMS

A. DEFINITION

A **system** is defined as “a collection of interdependent elements that interact to achieve a common purpose.”³

B. SYSTEMS THINKING

Systems thinking is a style of thinking/reasoning and problem solving that offers the clinician a broad based understanding of the concern. It starts with the recognition of system properties in a given problem.⁴ The “problems” are viewed as parts of an overall system, rather than reacting to specific parts, outcomes, or events and potentially contributing to the further development of unintended consequences. A physician that uses systems thinking will consider the many influences on a patient, their family and situation in addition to their symptom presentation. As the physician works with the patient and family to devise the treatment plan, they will be considering the multiple systems that are involved with the youth and family including how to interact/interface with these many systems to promote improved functioning in the youth and family.

There is a developmental progression that takes place within the CAP resident/clinician to develop the ability to work effectively in various settings and systems. First, the physician must acquire knowledge about systems and systems thinking. With a basic knowledge of systems, CAPs can then begin to process and problem solve as needed with individual patients and families to address issues. Then, the ability to adapt to new settings while using their system knowledge will help the CAP apply these lessons to their practice and systems.⁵ Masters of this competency will internalize the importance of systems thinking to the ethical practice of medicine and will become champions of systems’ changes towards improvement.⁶

C. TYPES OF CHILD-SERVING SYSTEMS

There are many different systems that serve children and families:

1. Primary Health Care System
2. Education System
3. Mental Health System
4. Child Welfare System

5. Juvenile Justice System
6. Developmental Disabilities System
7. Substance Abuse Treatment Services System
8. Early Childhood Services System

Most children in the U.S. are served by a primary care physician for developmental screening and health needs. A free and accessible public education is mandated in the U.S. and youth are required to be pursuing their education. So, most children in the United States are involved with the primary health care and education systems. The other systems are involved with youth as they have specific needs related to the mandates of these agencies (see specific system modules). For instance, if a 3 year old boy presents to the CAP office with delayed speech development and limited social interactions, they could refer him to the early childhood services system for a comprehensive developmental evaluation and treatment. The child psychiatrist's knowledge of the system helps him or her advocate for the child's needs beyond his or her field of expertise.

Child and adolescent psychiatrists need to have a thorough knowledge of the child-serving systems in order to adequately evaluate, diagnose, treat and advocate for their patients and families, and be in a position to promote coordination and cooperation among involved systems.

D. CHILD AND ADOLESCENT PSYCHIATRISTS IN SYSTEMS COLLABORATIVE PRACTICE

In child mental health outpatient clinics, residential and inpatient programs there has been a tradition of service models that enables the collaborative work of psychiatrists, psychologists, nurses, social workers, and occupational and recreational therapists, along with other specialists. The evolving standard of care requires collaboration between professional and paraprofessional personnel with a mandate for comprehensive interagency cooperation.⁷ Multidisciplinary mental health treatment services are increasingly co-located within other service system programs, such as schools or juvenile detention facilities, and other community settings. The child and adolescent psychiatry attending and resident physicians are vital team members and can lend an important voice on multiple levels.

LEADERSHIP ISSUES

What is a typical leadership role in a system context?

In collaborative practice, each and every member of the team is a leader and helps move the process along. The ultimate goal is to help the youth and family being served to become the leaders of their team. The multidisciplinary teams will frequently be led by the care managers who help all parties contribute to the process. The child and adolescent psychiatrist frequently lends expertise, while also advocating for the youth and family. The CAP's broad knowledge base and biopsychosocial orientation helps provide an important resource for the team. Indeed, the broad expertise of the CAP can help the team when there are challenges with or barriers to care. In working with these teams, the CAP

resident will learn more about the multiple roles they may have and how to be most effective to help youth and family and the overall team process.

MULTIPLE ROLES OF THE CHILD AND ADOLESCENT PSYCHIATRIST

The CAP can have a variety of roles while working with a youth and family, as well as when working with systems:

1. CAP as treating psychiatrist
2. CAP as a member of a team (i.e., child and family team)
3. CAP as a consultant to a system
4. CAP as an advocate for child and family
5. CAP as a collaborator between systems
6. CAP as an advocate for the system
7. CAP as a catalyst for system improvement

III. FOUNDATION PRINCIPLES for SYSTEMS BASED PRACTICE

A. ECOLOGICAL FRAMEWORK

BRONFENBRENNER'S ECOLOGICAL SYSTEMS THEORY

Ecological systems theory looks at a child's development within the context of the system of relationships that form his or her environment. This theory defines complex "layers" of environment, each having an effect on a child's development. The interaction between factors in the child's maturing biology, the immediate family/community environment, and the societal landscape fuels and steers the child's development. Conflict or changes in any one layer will ripple through other layers. To study a child's development, we must look at the child and his or her immediate environment, as well as the interaction of the larger environment.²

Figure 1 shows the child in the context of the family and larger community. Various child serving systems may be involved with individual children and their families as needs arise.



IMPLICATIONS FOR WORKING WITH YOUTH AND FAMILIES

Bronfenbrenner's ecological systems theory focuses on the quality and context of the child's environment. As a child develops, the interaction within these environments becomes more complex. So, how does the world that surrounds the child help or hinder this continued development? It is important to consider all of the possible influences when you work with children and families.

B. FAMILY-DRIVEN AND YOUTH-GUIDED CARE

Family-driven care 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.⁸ This includes:

1. Choosing supports, services, and providers;
2. Setting goals;
3. Designing and implementing programs;
4. Monitoring outcomes;
5. Partnering in funding decisions; and
6. Determining the effectiveness of all efforts to promote the mental health and well-being of children and youth.

An important component of family-driven care/youth-guided care is providing **strengths-based care** where strengths, as well as needs, are identified and used during the evaluation and treatment planning process. Services and supports must be individualized, built on strengths to meet the needs of the youth and family across all life domains in order to promote success, safety, and permanency in the home, school and community.⁹ It is also important for the CAP to provide **youth-guided care** by supporting the youth to have a voice and choice within the treatment process. Care must focus on increasing the youth's ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience. Furthermore, the integration of natural supports with professional services is a key element in helping youth and families achieve self sufficiency.

Practicing family-driven and youth-guided care is vital as a CAP (see AACAP's policy statement on "[Family and Youth Participation in Clinical Decision-Making](#)"). For the child-serving systems to work well they need to include the many **stakeholders** who are committed to the youth and his or her family. A **stakeholder** is a person or a group with a direct interest, involvement, or investment in the specific issue. There are many stakeholders concerned with youth and families including the family and friends, local community, as well as state and national community.

C. CULTURAL COMPETENCE

The concept and practice of **cultural competence** is important for all CAPs both as clinicians and advocates for their patients and families. Culture is a source of strength and can be promoted in clinical care. Cross and colleagues¹⁰ defined qualities that culturally competent practitioners and agencies must embody and achieve. For individual practitioners, this includes awareness and acceptance of cultural differences, awareness of their own culture and biases it may create, understanding the dynamics of working across cultures, acquiring cultural knowledge, and acquiring and adapting practice skills to fit

the cultural context of the client. There is also a need for agencies and institutions to evaluate their policies and procedures to incorporate culturally competent practice.

D. EVIDENCE-BASED PRACTICE

Evidence-based practice is an interdisciplinary approach which advocates that all practical decisions made should be based on research studies and that these research studies are selected and interpreted according to some specific norms characteristic of evidence-based practice. Indeed, the provision of effective evaluation and treatment services for children and families is one of the goals of every child and adolescent psychiatrist.

With this knowledge base tools have been developed by professional organizations, clinicians, policymakers, and investigators to promote appropriate and high-quality care while also emphasizing accountability.¹¹

Six different approaches in EBP to derive and implement quality include:

1. **Best practices:** set out fairly general statements about clinical practice.
2. **Practice guidelines:** diagnosis-specific interventions are evidence-based and may be consensus-based too.
3. **Clinical protocols/manuals:** designed to assure adherence to highly specific types of treatment.
4. **Quality monitoring:** used to monitor clinical practice, consists of general indicators to assess treatment or termination by level of care.
5. **Fidelity/adherence measures:** assess the extent to which a given intervention is provided as intended.
6. **Regulations:** specified for licensure, accreditation, or reimbursement by regulatory agencies.

This tool kit will address evidence-based practices as they apply in each module. Scientific evidence regarding treatment should be used judiciously to inform treatment decisions.¹² Many times the practitioner is faced with clinical situations where they will need to use this evidence along with their best clinical judgment.

IV. HISTORICAL PERSPECTIVE

Before 1970:

The earliest child mental health services in the U.S. were aimed at the population of homeless and wayward youth at the beginning of the twentieth century. The child guidance movement grew out of these earlier efforts and focused on serving the entire population. The development in the field of child mental health during this era helped lead to a new focus on the importance of the child's development, the role of the family, and the effects of societal forces on the child and family. The Federal Community Mental Health Center program (1960s) led to the development of local mental health centers to serve various populations including adults with severe and persistent mental health problems. Despite clear intentions to provide preventive services, children and families were not the focus of care. Various attempts were made to include services for children (e.g., Part F amendments, Mental Health Systems Act) with variable success due to lack of funding.^{13, 14}

1970 – 2000:

Jane Knitzer’s 1982 book, *Unclaimed Children*,¹⁵ provided an understanding of the state of child mental health and human services over the preceding decades. The study described a survey of child-serving agencies and a review of the most promising programs. A variety of agencies (e.g., child welfare, education, health, juvenile justice, mental health, substance abuse) had responsibility for children with emotional, mental, or behavioral disorders. These agencies did not have the resources or organization to serve the children adequately and this resulted in the children being passed back and forth among agencies. Of the three million children with the most severe disturbances, only a third of the children were receiving services and most of those were inappropriate. *Unclaimed Children* had a significant impact on government and advocates, and became a “call to action” for the nation to better meet the needs of children and adolescents with complex, multi-system needs.

In an effort to improve the system, the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) promoted more comprehensive service delivery. From 1984 to 1993 this was done through the Child and Adolescent Service System Program (CASSP) and since 1992 through the Comprehensive Community Mental Health Services Program for Children and Families (CCMHSPCF). These programs give small planning grants to state and local mental health agencies to organize joint programming among agencies at the state and local level. This framework has arisen out of recognition that: access to services has been limited; services available have not been well-coordinated, have been excessively restrictive, and often involved seeing families as part of the problem rather than as part of the solution; and cultural differences in populations served have received insufficient consideration. The system-of-care model emphasized that care should be tailored to the individual needs and strengths of the child and family and be community based in the least restrictive setting that meets their needs. The goals of CASSP included developing interagency systems of care, enhancing the role of child mental health agencies, enhancing the role of the family, and promoting cultural competence.¹²

2000 – 2010:

In 2001, the **Institute of Medicine (IOM)** made an urgent call for change in its report *Crossing the Quality Chasm: A New Health System for the 21st Century*.¹⁶ This report suggests changes to close the quality gap, recommends a redesign of the American health care system, and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others.

Summary of new “rules” for a 21st century health care system:

<i>Current Approach</i>	<i>New Rule</i>
<i>Care is based primarily on visits.</i>	<i>Care is based on continuous healing relationships.</i>
<i>Professional autonomy drives variability.</i>	<i>Care is customized according to needs and values.</i>
<i>Professionals control care.</i>	<i>The patient is the source of control.</i>
<i>Information is a record.</i>	<i>Knowledge is shared and information flows</i>

	<i>freely.</i>
<i>Decision-making is based on training and experience.</i>	<i>Decision-making is evidence-based.</i>
<i>Do no harm is an individual responsibility.</i>	<i>Safety is a system property.</i>
<i>Secrecy is necessary.</i>	<i>Transparency is necessary.</i>
<i>The system reacts to needs.</i>	<i>Needs are anticipated.</i>
<i>Cost reduction is sought.</i>	<i>Waste is continuously decreased.</i>
<i>Preference is given to professional roles over the system.</i>	<i>Cooperation among clinicians is a priority.</i>

Also in 2001, President George W. Bush announced his New Freedom initiative to promote increased access to educational and employment opportunities for people with disabilities. The initiative also promoted increased access to assistive and universally designed technologies and full access to community life. This presented an important opportunity for full community participation for all people with disabilities, including those with psychiatric disabilities. The President launched the **New Freedom Commission on Mental Health** to address the problems in the way services are delivered in the current mental health system.

The Commission concluded that the mental health system is not oriented to the single most important goal of the people it serves – the hope of recovery, with the following vision statement:

“We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essential for living, working, learning, and participating fully in the community.”¹⁷

To improve access to quality care and services, the Commission recommended fundamentally transforming how mental health care is delivered.¹⁷ This transformation was based on two major principles: 1) Services and treatments must be consumer and family centered; and, 2) Care must focus on increasing consumers’ ability to successfully cope with life’s challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.

The Commission also identified six goals as the foundation for transforming mental health care. These goals included:

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

In 2007, AACAP published the **“Practice Parameter on Child and Adolescent Mental Health Care in Community Systems of Care”** presenting overarching principles and practices for child and adolescent mental health care in community systems of care.¹⁸

Recommendations are derived from the system-of-care approach to service delivery, and include the following:

- 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 all community systems with which they are involved, including formal services as well as natural supports.
- Recommendation 2. The clinician should develop collaborative and strengths-based relationships with families, emphasizing partnerships at both the case-planning and system-planning levels.
- 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 (this can occur at the case, program, and larger systems level).
- Recommendation 4. Services should be culturally competent and should address the needs of underserved, culturally diverse, at-risk populations.
- Recommendation 5. To achieve individualization of care for children with significant and complex mental health needs, clinicians should consider a wraparound planning process.
- Recommendation 6. Treatment planning in systems of care should incorporate effective interventions supported by the available evidence base.
- Recommendation 7. Child and adolescent psychiatrists' roles in systems of care should include triage, provision of direct service (psychosocial therapies as well as pharmacotherapy), consultation to other service providers, quality improvement, program design, and evaluation and advocacy.
- Recommendation 8. Pharmacotherapy should be performed by a physician or medical practitioner who is integrated into the interdisciplinary process and has completed a biopsychosocial assessment, including interviewing the child and his or her parent or caregiver and reviewing relevant ancillary data.
- Recommendation 9. The clinician should be familiar with the organization and functioning of the system in which he or she is working in order to advocate effectively for adequacy of resources and practices to meet the needs of children and families served.
- Recommendation 10. The clinician and the family share accountability for treatment success. The system of care through its component programs should be accountable for clinical outcomes and actively involved in quality improvement efforts.
- Recommendation 11. Services should be delivered in 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.
- Recommendation 12. 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.
- Recommendation 13. Systems of care should incorporate prevention strategies in clinical practice and system design.

In 2008 the **National Center for Children in Poverty**¹⁹ undertook a study to assess how current child mental health policies across the United States respond to the needs of children and youth with mental health problems, those at risk, and their families. The report from this study, entitled *Unclaimed Children Revisited* after Knitzer's original publication, found that policies and programming have not kept pace with the explosion of knowledge about mental illness, prevention and treatment that has occurred since the original publication of *Unclaimed Children*.

The study found that while the vast majority of states are taking tangible steps to improve their mental health delivery systems for children, there continue to be, too few resources dedicated to developing a comprehensive framework that addresses the needs of children and youth with or at risk for mental health conditions and their families.

In 2009, the **Institute of Medicine** published a new report entitled "*Preventing Mental, Emotional, and Behavioral Disorders Among Young People; Progress and Possibilities.*"²⁰ The report describes the broad range of relevant research and concludes that it is critical to shift the focus to advancing health and preventing disorders from occurring in the first place rather than waiting until a disorder is well established and has done considerable harm. The report calls on national, state, and local leaders to make the prevention of mental, emotional, and behavioral disorders and the promotion of mental health among young people a priority.

Furthermore, the IOM report identifies the need for a more coordinated approach to mental health prevention research among the various stakeholders. The report recommends that the National Institutes of Health develop a 10-year research plan in conjunction with other groups that fund prevention research. It also calls for parity in funding between prevention and treatment research.

2010 and beyond:

In 2010 the *System of Care Concept and Philosophy*²¹ was updated by the original authors, including a revised definition and delineation of core values and guiding principles. A system of care was defined as a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life. The entire update is included in Appendix 2.

On March 23, 2010, the **Patient Protection and Affordable Care Act (PPACA)**²² was signed into law. This important change in healthcare in the United States will have implications for the child and adolescent psychiatrist practicing in child-serving systems. In addition to the insurance and coverage changes included in PPACA, there are provisions that expand access to mental health care, services and research (school-based health clinics, coordinated/integrated care, youth suicide prevention, and Centers of Excellence for Depression). It will be important for child psychiatrists to follow the implementation of the PPACA and the challenges that arise. As advocates for our patients, one goal is to continue to encourage the enactment of federal health policy that will promote improvements in child serving systems and ultimately promote improved outcomes for youth and families.

V. CONCLUSION

Child and adolescent psychiatrists work with and in many child serving systems. In this endeavor child psychiatrists can have a variety of roles in systems based practice and promote the principles of family- driven, youth-guided care; cultural competence; and evidence-based practice. There have been many developments recently that influence systems and mental health policy. The ability for child and adolescent psychiatrists to be able to understand and navigate systems is a key competency in order to successfully practice and achieve positive patient outcomes.

APPENDIX 1*

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

- 1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- 2) coordinate patient care within the health care system relevant to their clinical specialty;
- 3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- 4) advocate for quality patient care and optimal patient care systems;
- 5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
- 6) participate in identifying system errors and implementing potential systems solutions.
- 7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
- 8) practice cost-effective health care and resource allocation that does not compromise quality of mental health care for children and adolescents;
- 9) advocate for quality patient care and assisting patients in dealing with system complexities, including disparities in mental health care for children and adolescents;
- 10) work with health care managers and health care providers to assess, coordinate, and improve health care;
- 11) know how to advocate for the promotion of health and the prevention of disease and injury in populations; and,
- 12) instruct in the practice of utilization review, quality assurance and performance improvement.

* Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry. http://www.acgme.org/acWebsite/downloads/RRC_progReq/405pr07012007.pdf. Accessed July 28, 2009.

APPENDIX 2

System of Care Concept and Philosophy Updated²¹

DEFINITION

A system of care is:

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

CORE VALUES

Systems of care are:

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

GUIDING PRINCIPLES

Systems of care are designed to:

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.

7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and services should be sensitive and responsive to these differences.

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WEB RESOURCES

American Academy of Child and Adolescent Psychiatry (AACAP): www.aacap.org

American Academy of Pediatrics (AAP): www.aap.org

Federation of Families for Children's Mental Health: www.ffcmh.org

Find Youth Info: www.FindYouthInfo.gov

The Institute for Patient- and- Family Centered Care: www.ipfcc.org

National Alliance on Mental Illness (NAMI): www.nami.org

Mental Health America: www.mentalhealthamerica.net

Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov

Youth M.O.V.E. National (Motivating Others through Voices of Experience):

<http://youthmovenational.org>