SYSTEMS-BASED PRACTICE
THE PUBLIC MENTAL HEALTH SYSTEM

SYSTEMS-BASED PRACTICE: PUBLIC MENTAL HEALTH SYSTEM OBJECTIVES

Knowledge
The resident will demonstrate an adequate knowledge of:
1) The public health mission of the mental health system. (1-3)
2) CASSP Principles as applied to clinical and institutional practice. (2,4,5,10)
3) The evolving continuum of care in mental health. (1-5,7,10)
4) Tools and paradigms of practice in the public sector. (1,2,4,5,7,9,10)
5) Organizational characteristics of the community mental health system. (11,12)
6) Roles and responsibilities for the child and adolescent psychiatrist in public mental health. (1-12)
7) Advocacy and accountability issue in the mental health system. (4-11)
8) System of care priorities and service options. (1,2,5-7)
9) The mental health system’s role in other child-serving systems. (3-5,10)

Skills
The resident will demonstrate the ability to:
1) Provide diagnostic assessment, clinical formulation, treatment planning, and other services in an interdisciplinary, multi-agency context. (1-3,5,6)
2) Diagnose and treat mental health disorders within the ecological and cultural context of family and community. (1,2)
3) Communicate clearly about psychiatric illness with youth and family, other professionals and the public. (4)
4) Collaborate in service design and delivery with other child-serving agency professionals. (6,7,10)
5) Advocate for individual child and family units and for needed system reforms and enhancements. (4,11)

Attitude
The resident will demonstrate the commitment to:
1) CASSP Principles in public mental health activities, organizing treatment within context of family, community and culture. (7,9,10)
2) Integrating child psychiatric professionalism and knowledge in system of care programs. (8,10)
3) Asserting the values of family-centered practice, including a commitment to individualized, strengths-based interactions with the child and family. (4,9)
4) Appreciating the challenges experienced by children and their parents, including issues of stigma. (4,11)
5) Advocating for children and their families, whenever needed. (8,12)

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

Community mental health services are organized and financed under a variety of mandates, incentives and guidelines that devolve from the federal government to state and local government entities. Within each community, programs are configured based on local needs, priorities, resources, constraints, historical idiosyncrasies and political factors.

The mission of these systems is to address the problems of morbidity and mortality from mental illness.

Of most particular significance are children and adolescents:
1. with severely impairing and chronic mental health disorders (i.e., Serious Emotionally Disturbed or SED);
2. without access to services because of poverty or other constraints; and
3. who are involved in other public sector systems such as child welfare, juvenile justice, special education, developmental disabilities, among others.

Child and adolescent psychiatrists (CAPs) are key participants and can be pivotal in leadership of local community mental health programs.

II. HISTORICAL CONTEXT

Efforts to provide professionally-guided mental health services for children and adolescents date to the late 19th century. In the early 20th century, progressive social policy efforts led to the child guidance movement, which adopted elements from the evolving fields of psychology, psychoanalysis, social work, nursing and medicine. These were followed in mid-century by the rise of academic sub-specialization, the establishment of organized treatment facilities and institutions, and the revolution of pediatric psychopharmacology.2

In the past three decades, the federal commitment to children’s mental health has been guided by the priorities of the Child & Adolescent Service Systems Program (CASSP) Guiding Principles for the System of Care, a set of contextual and ecological values and practices that prioritize child-centered, family-focused and community-based care (See Appendix II).3

In 1994, the Substance Abuse Mental Health Services Administration’s (SAMHSA) Center for Mental Health Service’s (CMHS) Child Youth and Family Branch began offering Children’s Mental Health System of Care grants to states, counties, Indian tribes and other responsible jurisdictions which have encouraged the:
- reorganization and expansion of mental health services for children and youth, and
- implementation of systems of care for children and families based on CASSP Principles.

These efforts have encouraged the development of services that are:
- focused on engagement and empowering youth and families and communities,
- organized in collaboration across child-serving agencies, and
- informed by the science of clinical practice.4
III. MISSION

Public mental health systems are responsible for providing clinically relevant intervention for children and youth with serious mental health disorders. Services provided are geared toward addressing the public health needs of a community in the arena of mental health. Success in these endeavors has an impact in reducing social burden and related costs of untreated mental illness to society.5

IV. VALUES

The CASSP Principles have been the driving policy force in public mental health for children since their elaboration under the aegis of the National Institute of Mental Health (NIMH).3 Coupled with the advancing scientific base of clinical practice, CASSP Principles form the basis for the system of care model that has evolved as the organizing framework for public mental health service systems in the 21st century.

The system of care model incorporates:
- a bio-psychosocial perspective
- a developmental approach
- a family-systems orientation
- youth-guided care approaches
- concepts of recovery and resiliency
- advocacy for family empowerment
- strengths-based approaches
- interdisciplinary collaboration
- multi-agency coordination
- continuity of care

The system of care approach seeks to reduce stigma and emphasizes engagement of parents and youth in the planning and implementation of their care and service plans. Family representation and voice are explicitly supported at levels of governance, service design, and in individual case advocacy.6 See also the AACAP policy statement on “Family and Youth Participation in Clinical Decision-Making” (http://www.aacap.org/cs/root/policy_statements/family_and_youth_participation_in_clinical_decisionmaking).

Child-adolescent psychiatric trainees need to become proficient in their application of their evolving professional skill set within the context of CASSP-guided system of care principles, programs and services.7

V. TARGET POPULATIONS: SED & OTHER GROUPS

Local mental health systems serve as a component of the larger societal health and safety networks, working in association with the health care community, law enforcement and other child-serving agencies (i.e., education, juvenile justice, child welfare, developmental disabled, substance abuse).

© 2009 American Academy of Child and Adolescent Psychiatry
Systems are responsible for serving a core target population of youth with SED, i.e., youth whose illness substantially interferes with their family life, their ability to learn, and their capacity to function in community activities. Within mental health, a DSM psychiatric disorder coupled with a significant functional impairment is a required criterion for the designation.8

DSM disorders related to developmental disability and substance abuse per se are excluded from the mental health services target population, yet they are frequently served within mental health when they exhibit co-occurring disorders that require mental health and psychiatric intervention. While available to all in need, the population served is typically of lower socioeconomic status, with characteristic patterns of cultural and ethnic minority representation.

Estimates of the prevalence rates for SED vary considerably based on the populations screened, the assessment tools utilized and the criteria of impairment or severity required, however, even with application of conservative criteria, an estimated 5-10% of children and adolescents present with this level of impairment.9

The definition of SED varies between child-serving agencies and this occasionally leads to difficulties in collaboration. In the education system, the criteria are set by federal IDEA legislation to include:

1. An inability to learn which cannot be explained by intellectual, sensory, or health factors.
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
3. Inappropriate types of behaviors or feelings under normal circumstances.
4. A general pervasive mood of unhappiness or depression.
5. A tendency to develop physical symptoms of fears associated with personal or school problems.
6. The term includes students who are schizophrenic. The term does not include students, who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.

With the expansion of mental health capacity and with growing acceptance of the value of early recognition and treatment, public mental health systems also now pay increasing attention to youth presenting with less severe impairment with the goal of reducing the risks of illness progression and consequent dysfunction and disability in the population.

Age Range: The child and adolescent mental health system is most typically focused on providing care for children and youth between the ages of 5 through 18 years of age. This school age standard has in recent years been expanded to include:

- Transition Age Youth: Youth over 18 years of age may continue to receive services through the child and adolescent mental health system up through age 22, particularly when the youth continues to have school-driven service planning and needs.
- Early Childhood Populations: Early intervention mental health programming for at-risk preschool children (ages 3 to 5 yrs), as well as, consultative services for younger children (ages 0-3 yrs) are increasingly common.
Legal status: With the exception of situations of acute danger and risk to life and safety, mental health services are provided on a voluntary basis as expressed by the youth’s parent(s) or guardian of record.

For children involved with the juvenile court system either through child welfare or probation systems, designees of the court may function, *in loco parentis*, to authorize treatment services, and in many jurisdictions to oversee aspects of psychotropic medication interventions.

Some communities allow for adolescents over the age of 14 to seek voluntary services without parental authorization, though typically with the expectation that parental involvement will occur, if feasible, following initial evaluation and crisis interventions.

VI. SERVICE ARRAY: THE EVOLVING CONTINUUM OF CARE

The array of services provided in public mental health systems is often conceptualized within the construct of the continuum of care, ranging from tertiary levels of intensive intervention for those most severely and/or acutely ill, through to secondary outpatient levels of care for those with relatively stable disorders and impairment, and, finally reaching out to at-risk populations with outreach, early identification and prevention efforts.

Elements of a mature traditional continuum of care would include:
- long-term state hospital
- acute hospitalization and crisis intervention
- residential services (long-term and short-term)
- day treatment (partial hospitalization)
- office-based outpatient clinical services
- consultation to school and/or agency
- prevention and early intervention programs

In recent years, there have been significant modifications to the continuum of care, with an increasing:
- focus on community-based services as opposed to out-of-home care,
- provision of intensive services in less restrictive settings,
- collaboration and joint programming with other child-serving agencies (e.g., education, child welfare, juvenile justice, substance abuse, developmental disability), and
- utilization of paraprofessional service extenders in “naturalistic community settings.”

Examples of system of care service programs include:
- In-home mental health support services, e.g. respite support led by paraprofessionals, supervised by clinical managers, implementing behavior modification protocols with families
- Case-based consultation and treatment services in child-serving agency settings, e.g. outreach mental health case management and clinical services provided for at-risk children in foster homes
- School-based services, e.g. counseling, interdisciplinary team treatment; intensive day treatment services offered within the schools

© 2009 American Academy of Child and Adolescent Psychiatry
- Services provided for youth in out-of-home settings, e.g. facility-based interdisciplinary services, targeting youth in 24-hour care facilities such as receiving homes, juvenile detention sites, or residential placement facilities
- Emergency screening/stabilization, e.g. site-based or mobile units available to provide mental health screening, evaluation and treatment services, including referral to inpatient care

VII. TOOLS AND PARADIGMS OF PRACTICE IN THE PUBLIC SECTOR

A variety of practice patterns and paradigms are used. These include both traditional elements and evolving elaborations of system of care practice.

A. Traditional Elements: Public mental health settings have fostered numerous comprehensive mental health care practices.
   1. Clinical Formulation: Bio-psychosocial formulation and developmental perspective are central to assessment and treatment planning with children and families.
   2. Treatment Plan: A treatment team with participation of the youth and his/her family, formulates a treatment plan, in collaboration with other involved systems, to address the presenting and defining problem(s). Goals and objectives of interventions, responsibilities and time frames are set.
   3. Interdisciplinary Teams: Services are provided by an interdisciplinary clinical team.\(^\text{11}\)
      - In a simple situation, the team may include the child and parent(s) and a lead clinician as direct participants.
      - In more complex and challenging cases, the interdisciplinary team may be quite large including a child psychiatrist, other licensed mental health providers, specialized consultant evaluators, and various licensed and unlicensed providers.
      - Members of the youth’s nuclear and extended family and members of the community should be participants in treatment teams.
   4. Professional Training Centers: Public mental health agencies and university affiliated training centers collaborate in educating future clinicians. Public mental health programs also serve as post-graduate settings where needed hours for licensure and supervision are obtained.
   5. Safety Net Services and Providers: While the use of inpatient care has been subject to limits under the influence of managed care, safety net interventions remain necessary to address acute crises of disability, dysfunction, and suicidal and homicidal tendencies.

B. System of Care Practice Concepts/Elements: CASSP Principles continue to provide direction for system development.
   1. New Roles for the Family: Family engagement and involvement are more central in assessment, treatment planning, treatment implementation, outcomes evaluation and transition/termination processes. Issues of strengths-based formulation, natural community resources and the concept of recovery all relate to provide youth-guided, family-driven care.\(^\text{12}\)
2. Cultural Competency: Culturally competent care is an organizing principle for service design and delivery, in recognition of the impact culture, ethnicity and language have upon the presentation of mental health problems. Care should be welcoming, accessible, attend to linguistic and cultural capabilities and support therapeutic engagement.\textsuperscript{13,14}

3. Community-Based Services: Service delivery in naturalistic community settings is supported. A broader array of service interventions is available.
   a. Setting\textsuperscript{s} such as schools, homes, foster homes, group homes, residential centers and other congregate care facilities (e.g., juvenile detention sites and child welfare shelter care, etc.) are sites for service delivery.
   b. Services provided may be quite sophisticated including intensive, interdisciplinary programming (e.g., day treatment and intensive outpatient).

4. Expanded Case Management: There has been substantial expansion of the use and scope of activities in case management supports for youth with serious emotional disorders. Case managers may be licensed clinicians, paraprofessional staff, or others from the community.

5. Non-Traditional Services and Providers: With a focus on resiliency, recovery and community functioning, programs make use of a variety of support services to enhance adaptation and functionality in naturalistic environments.
   a. Wraparound: Wraparound encompasses a variety of in-home and in-community services that promote adaptation. Wraparound services are provided in conjunctive with traditional clinical service. Examples: respite care for parents, mentoring-socialization supports for youth, behavioral modification skills training for parent-youth dyad, etc.\textsuperscript{15}
   b. Para-Professional Service Providers: Child-family workers provide behavioral services in home and community settings by protocol with support of licensed supervisory staff. Family or other community members, referred to as “informal supports,” may be designated to function in these capacities.
   c. Peer Partnership Programs: Mentoring and facilitative support are provided by parents or older youth who have successfully transitioned through the mental health (and/or an associated child-serving) system. Peer Partner staff may be paid or volunteer.

6. Multi-Agency Collaborative Practice: Collaborative practice by mental health and other child-serving agencies is central to System of Care philosophy.
   a. Education & Special Education: Mental health problems are often first recognized in schools. Youth in special education settings have significant needs for mental health services.\textsuperscript{16}
   b. Juvenile Court: The Court’s officers and its subordinate child-care agencies (probation and child welfare) have great need for consultation and guidance in matters related to mental health problems of their at-risk populations.
   c. Child Welfare: Children and adolescents exposed to neglect and abuse have extensive mental health concerns related to their exposure to trauma, displacements and disrupted living circumstances.
   d. Juvenile Justice: Youth in trouble with the law are at exceptional risk for mental health difficulties, either as underlying causes of their antisocial behavior or in consequence of their involvement with the court and probation systems.\textsuperscript{17}
f. Substance Abuse: Youth identified as having substance abuse problems are at high risk for having co-occurring mental health disorders and other psychosocial challenge that impede their recovery and progress.

g. Developmental Disabilities: Developmentally disabled children have contact with the mental health system in consequence of their vulnerability to behavioral and mental health disorders.

h. Primary Care: Consultation with pediatric primary and specialty medical care providers and institutions aids in the arenas of access, identification, and aftercare.

i. Early Childhood: Efforts in support of early recognition, formal assessment and strategic clinical intervention are increasing.

7. Youth in Out-of-Home Care: A significant number of youth still live in one or another form of placement out of their homes and away from their families and local communities. CMHS has recently initiated a project, Building Bridges, to establish better dialogue between residential and community-based service delivery providers, families and youth and to reduce further exacerbations of illness and progression of developmental problems.  

8. New Technologies: As in other arenas, mental health practices are being shaped by evolving technologies, with both telepsychiatry and electronic medical records (EMR) being utilized with increasing frequency by public mental health systems. These technologies offer opportunity to address concerns about quality improvement and access to care.

VIII. CHILD/ADOLESCENT PSYCHIATRISTS IN PUBLIC MENTAL HEALTH SYSTEMS

The CAP working within a public sector mental health program may have a variety of roles and responsibilities but invariably will be working within the larger context of an interdisciplinary interagency setting where many of his/her unique skills as a physician may be called into play. Regardless of the specific roles assumed by a child/adolescent psychiatrist in a public sector program, he/she needs to assert and retain leadership as the physician with oversight role of psychiatric and physical health aspects of care.

- For inpatient level services, physician determination of “medical necessity” is a Medicaid requirement.
- For outpatient services, the psychiatrist’s clinical skills and broad expertise provide a basis for their leadership in clinical assessment, diagnosis and treatment recommendations congruent with interdisciplinary and family-focused practice.

Service Role Opportunities for Child/Adolescent Psychiatrists:

1. Providing psychiatric assessment and evaluation of the child.
2. Acting as the treating psychotherapist for child and/or family.
3. Prescribing and monitoring psychotropic medication.
4. Consulting and as liaison for medical care issues.
5. Participating as contributing member of the child and family team.
6. Consulting to a public mental health system or to another child-serving agency.
7. Performing court-requested evaluations (CPS and probation).
8. Performing evaluations for other agencies (schools, etc.).
9. Acting as an advocate for a child/family or a class of children/families.
10. Serving as medical director of programs or a system.
11. Serving as an administrator of system.

Knowledge Base for CAPs in Public Mental Health Settings:
1. The CAP needs to know about public mental health system mandates, roles and responsibilities.
2. The CAP needs to know about affiliated child-serving systems, and to have an awareness of the range of mandates, available services, challenges and potential outcomes for children and families in these systems.
3. The CAP should be cognizant about and accepting of child-centered and family-focused practices, a core value of the public mental health system.
4. The CAP should be familiar and comfortable with the principles of partnership and collaboration with families consistent with system of care principles, and with comparable system of care principles as they apply across all categorical service systems.
5. The CAP should be able to utilize his core knowledge and acquired professional skills in concert with the values and efforts of other child-serving systems as they relate to societal supports and collaborative interventions with children and youth, families.
6. Potential roles and opportunities for the CAP need to be understood, and CAPs are encouraged to become involved in systems of care services.

IX. ORGANIZATION OF THE SERVICE SYSTEM

A. The Provider Network: Providers in the public mental health network work under the policy guidance and fiscal management of the designated local public mental health authority.
   - Some systems rely on publicly employed clinical staff and programs; these staff are typically involved in oversight and management functions.
   - Most systems outsource service delivery to not-for-profit entities and/or individual providers.
   - Academic training programs are commonly involved in operations and/or staffing of mental health programs. The public sector is a key training ground for professionals in the mental health field.
   - Private for-profit organizations may provide services when there is no capacity in the not-for-profit sector (e.g., inpatient psychiatric care).
   - Independent mental health clinicians may participate as:
     - Employees of the governmental or not-for-profit entities,
     - Contract staff with agencies,
     - Fee-for-service providers in private practice.

B. Agency Practice: Often, provider agencies must weave together funds derived from sources that may have different guidelines, fiscal years, and missions. Funds may come to agencies:
   - on a per capita basis,
   - on a “fee for service” or reimbursement basis, and
• in the form of grants for specific sub-populations.

Access to care is regulated in various ways:
• Some services are paid for regardless of who accesses them (e.g., emergency services).
• Higher cost, higher intensity programs (e.g., inpatient, day treatment, residential, case management) typically require greater illness severity and disability.
• Eligibility for Medicaid funding can be achieved through poverty status or disability status.
• In some states, funds are funneled through federally approved managed care frameworks while others adhere to federal program guidelines.
• In some states, counties present an additional level of administration.

C. Other sources of mental health services: Many communities rely heavily upon other providers of mental health services including:
• Private sector professionals who care for individuals covered by insurance or those able to pay privately.
• Pediatricians in private practice and those working in Community Health Centers are a significant resource for treating youth with common, relatively uncomplicated mental health problems.

X. THE ROLE OF GOVERNMENT:

Public mental health services are a product of the complex interaction of federal, state, and local government action in the form of policy development and implementation and financing requirements and incentives.

A. FEDERAL INVOLVEMENT
Federal involvement in mental health care delivery occurs through agencies of the U.S. Department of Health and Human Services (HHS):
• SAMHSA's CMHS administers the Mental Health Block Grant to states for providing mental health services to people with mental illnesses.
• Medicaid and Medicare (administered by CMS) represent the greatest share of the federal contribution towards mental health care. Funds are disbursed through state benefits agencies and must be matched by state dollars. The lion’s share of funding comes from the Medicaid program of which the Early & Periodic Screening Diagnosis and Treatment ( EPSDT) eligibility has been a major resource for children’s public mental health systems.
• Federal government plays an important role in promoting, implementing, and disseminating research through the National Institutes of Health, specifically the National Institute of Mental Health (NIMH).

B. STATE INVOLVEMENT
State mental health agencies fulfill the numerous responsibilities in compliance with a federally approved state plan. State agencies are responsible for:
• Administering federal and state mental health dollars.
• Providing public mental health services pursuant to a state plan.
• Certifying and regulating mental health care providers.
• Developing and implementing programs.
• Monitoring quality and cost of public mental health services.
• Brokering federal Medicaid and allocating state matching funds.

C. LOCAL GOVERNMENT INVOLVEMENT
In larger states, county or other local jurisdictions may be designated to assume local responsibility for the local system of care. They then work with and through the state to meet the federal and state guidelines, with opportunity for further local elaboration of requirements within a fed-state-local framework.

D. FUNDING
The majority of funding for public mental health programs comes from government sources with a multiplicity of funding streams at federal, state and local levels. Other funding may come from user fees, insurance payments, and private grants. All told, the funding mechanisms are quite complex.

Eligibility for services is fairly universally driven by the criteria of eligibility in each state’s Medicaid plans with the requirement of a designated diagnosable condition in the DSM system.

While the federal regulations for Medicaid reimbursement are quite specific, there are mechanisms for innovative practices and various states and communities have applied for variances from the standard procedures to allow for innovative financing and organizational activities. The Medicaid waiver processes (115 waivers and 1915C waivers) are the most prominent mechanisms used to increase local flexibility in allocation of federal Medicaid supports.

State and local funding is required as matching funds for most federal dollars, but localities have also taken action to develop and sustain funding outside of the Medicaid system. Most prominently, California, through its initiative process recently augmented its baseline financial support to mental health through the passage and implementation of the state’s Mental Health Services Act, with a variety of priorities and program guidelines.

XI. ADVOCACY AND ACCOUNTABILITY

A. Advocacy: Mental health services are primarily delivered at the community level where local elaboration introduces a layer of political process and where advocacy plays an important role. Advocates are key actors in providing community input to help define policy direction and help prioritize the allocation of resources within a system. Participants in the mental health advocacy may include individual consumers of services, family members, providers of service and others.

Advocates may act independently or participate in the process as members of organized groups. Prominent consumer advocacy groups that operate nationally and locally include: Mental Health America, the National Alliance for the Mentally Ill, and the Federation of
Families, amongst others. Legal advocacy groups (e.g., locally: Legal Aide Society, nationally: Bazelon Center for Mental Health Law), ethnic community interest organizations (e.g., Urban League, etc.), and organized provider and professional groups may also be important participants in the advocacy agenda.

Legislative strategies may be utilized to support and enhance the service system. At the political level, many state and local advocates have worked to establish the governmental commitment to the mentally ill through legislation that defines in statute both the policy and the program requirements of mental health programs. This can be most helpful in times of fiscal or other challenge by providing a standard that can be used to promote practice enhancements and/or to prevent retrenchment in funding or commitment.

Class action lawsuits have been another vehicle for promoting enhancement of funding and elaboration of more responsive services within the public mental health arena. Hawaii’s statewide system was challenged in court in this manner with resultant court oversight and subsequent reform to their system of care. Arizona was similarly involved in a class action suit and Massachusetts is presently working under court supervision to resolve a claim for increased access to services.

B. Outcomes and Monitoring: Linked with the effort to advocate for improved services and, in consideration of the large investment of resource in public mental health, there is great interest in providing oversight on outcomes from service delivery systems.

Most mental health systems make a concerted effort to evaluate and report on the outcomes of their service systems for both programmatic and policy/political purposes. Efforts to evaluate these concerns take place at various levels with interest both in client-centered evaluation as well as system-centered review.22

Typical systems level outcomes measures: reductions in out-of-home care, improvement in functioning, client and family satisfaction, etc. A variety of clinical tools and instruments are utilized in this effort and the art and science of system evaluations continues to progress. Among the evaluation tools in common use are the: CAFAS (Child and Adolescent Functional Assessment Scale), CANS (Child and Adolescent Needs and Strengths), CBCL (Child Behavior Check List) and others.

In the effort to improve clinical decision-making processes, particularly in the context of treatment planning efforts within a system of care model, the AACAP has supported the development of the Child and Adolescent Service Intensity Instrument (CASII),23 which provides guidance in treatment planning utilizing an algorithm that assesses numerous clinical factors including risk, resilience, treatment engagement and other factors. A companion tool for use in early childhood treatment planning, known as the Early Childhood Service Intensity Instrument (ECSI),24 provides a similar algorithm appropriate to that age range.
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.

APPENDIX II

CASSP Guiding Principles for the System of Care

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.
3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.
5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.
6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.
10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.
REFERENCES


WEB RESOURCES

Federation of Families for Children’s Mental Health
http://www.ffcmh.org/

CASSP
http://www.omh.state.ny.us/omhweb/ebp/cassp.htm
http://www.dpw.state.pa.us/Omap/rfp/SEStndsReq/omapSESRappI.asp

SAMHSA
http://mentalhealth.samhsa.gov/topics/explore/children/

Medicaid
http://www.cms.hhs.gov/home/medicaid.asp

Serious Emotional Disturbance
http://en.wikipedia.org/wiki/Serious_Emotional_Disturbance

Developmental Disabilities
http://www.thenadd.org/

Substance Abuse
http://www.nida.nih.gov/NIDAHome.html

Child Welfare
http://www.childwelfare.gov/

Advocacy & Policy
http://www.futureofchildren.org/
Mental Health System – Discussion Vignette I – Trainee Version

Five year old Jeff lives under the guardianship of his widowed working grandmother who is struggling in her efforts to maintain a steady income, coordinate Jeff’s school and after-school placements, and negotiate and coordinate the court sanctioned contacts between Jeff and his mother who struggles with her own social-emotional problems.

An intensive outreach mental health program operating in coordination with the local elementary school district provides thorough diagnostic assessment, initiates supportive psychotherapies in school and at home, refines medication management, offers counsel and “buffering” with the mother, consults with the local child welfare agency and provides case crisis management services (locating a temporary after-school program when the youth is expelled for misbehavior).

After a total of 8 months of services, medication management responsibility is returned to the pediatrician and outreach efforts are tapered off as the grandmother is referred to community resources in the school and to local child care agencies for ongoing support. The end result of this multi-tiered collaborative service program is that Jeff’s life is normalized and the long term risk and cost of his potential dislocation from family and community is averted.

1. Identify and discuss CASSP Principles illustrated in this case.

2. What was the role of the child psychiatrist in working with this child and family?

3. Cultural competent care is important in a system of care. What are factors that are determinants of successful engagement of the family?
Mental Health System – Discussion Vignette II – Trainee Version

A group of program managers responsible for the care and placement of seriously emotionally challenged youth for their community had often found themselves in crisis or conflict over who would or could take primary responsibility for placement and service delivery for a child. A meeting of representatives from mental health, child welfare, juvenile justice, and developmental services was convened with a monthly calendar to review those cases where roadblocks in case management were preventing appropriate disposition and service provision. Informally known as the “Hot Potatoes Group,” this multi-disciplinary forum allowed for creative case management strategies to meet client needs and reduce interagency conflicts.

One teenage girl who had been bounced back and forth between mental health, child welfare, and developmental disability agencies in several states was ultimately placed in a skilled nursing facility where her underlying neurological and medical handicaps were better able to be served, ending years of being bounced around to inappropriate placements.

1. Identify and discuss CASSP Principles illustrated in this case.

2. Identify possible roles played by the child psychiatrist in interagency multi-system consultation systems such as that described above. What unique skill sets and attitudes does the child psychiatrist bring to the discussion?

3. The array of services provided in public mental health systems is conceptualized within the construct of the continuum of care. List the elements of a mature traditional continuum of care.
4. With the dissemination of CASSP Principles there have been modifications to the continuum of care with an increasing emphasis on new elements. Please list these elements that help improve the continuum of care.
Mental Health System – Discussion Vignette III – Trainee Version

Alfredo is a 13 year old and on his way to a “career” in the juvenile justice system. Although his non-English speaking parents managed to obtain adequate services for him during his latency years and he’d managed to make it through elementary school in spite of significant learning handicaps and moderate behavioral problems, with the onset of adolescence he has become involved in petty delinquencies and his functioning in school and with peers has deteriorated substantially.

After several incidents, he is placed in a court authorized and probation supervised day school program capable of containing and controlling his behavior, while meeting many of his basic education needs and providing mental health interventions. Upon “graduation” from this program, the youth is referred to a culturally sensitive, intensive outreach case management program that engages with the parents to coordinate an optimally appropriate school placement, obtain psychiatric consultation for refinement of medication management, and develop after-school linkages for pro-social peer involvements.

The bilingual, bi-cultural paraprofessional case manager provides the “glue” to create a successful alliance between the family and the community service systems. The family-centered continuity of care provided in this system of care program provides Alfredo’s family a second chance to obtain the multi-modal and interagency services he will need to proceed successful through his adolescence.

1. Identify and discuss CASSP Principles illustrated in this case.

2. Identify the concerns faced by the treating child psychiatrist in different phases of treatment and discuss external resources required to allow for effective psychiatric contributions to the intervention program.
3. Identify other supplemental resources that might be appropriate for the above referenced case.

4. Alfredo received many different services from different agencies. Identify three potential funding sources for mental health services that might apply to this youth and family.

5. List the ways access to care is regulated.