

# **SYSTEMS-BASED PRACTICE THE MENTAL HEALTH SYSTEM Updated April 2020**

## **SYSTEMS-BASED PRACTICE: MENTAL HEALTH SYSTEM OBJECTIVES<sup>□</sup>**

### **Knowledge**

The resident will demonstrate an adequate knowledge of:

- 1) The public health mission of the mental health system.
- 2) System of Care Values and Principles.
- 3) The evolving continuum of care in children's mental health.
- 4) Tools and paradigms of practice.
- 5) Organizational characteristics of the community mental health system.
- 6) Roles and responsibilities for the child and adolescent psychiatrist in the mental health System of Care.
- 7) Advocacy and accountability issue in the mental health system.
- 8) Federal laws that impact funding for child and adolescent mental health services
- 9) The mental health system's role in other child-serving systems.

### **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 based on a SOC approach.
- 2) Diagnose and treat mental health disorders within the ecological and cultural context of family and community.
- 3) Communicate clearly about psychiatric illness with youth and family, other professionals and the public.
- 4) Collaborate in service design and delivery with other child-serving agency professionals.
- 5) Advocate for individual child and family units and for needed system reforms and enhancements.

### **Attitude**

The resident will demonstrate the commitment to:

- 1) SOC Values and Principles in public mental health activities, organizing treatment within context of family, community and culture.
- 2) Integrate child psychiatric professionalism and knowledge into other child serving disciplines and agencies within the System of Care.
- 3) Asserting the values of family-driven, youth-guided practice, including a commitment to individualized, strengths-based interactions with the child and family that are culturally sensitive.
- 4) Appreciating the challenges experienced by children and their parents, including issues of stigma.
- 5) Advocating for children and their families, whenever needed.

Appendix 1 describes the systems-based practice competency in the RRC Program Requirements

## I. INTRODUCTION

Mental health services for children and adolescents are organized and financed under a variety of mandates, incentives and guidelines that are determined by federal government as well as state and local government entities. Within each community, programs are configured based on local needs, priorities, resources, constraints, historical idiosyncrasies and political factors. The federal government and most states organize mental health services to be consistent with a System of Care (SOC) approach. A recent American Academy of Child and Adolescent Psychiatry Clinical Update on System of Care provides background on System of Care as the dominant framework for supporting children’s mental health.<sup>2</sup>

The mission of these services in the mental health system is to address the problems of morbidity and mortality from mental illness.

Of most particular concern are children and adolescents:

1. with severely impairing and chronic mental health disorders
2. without access to services because of poverty or other constraints; and
3. involved in 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 the leadership of local community mental health programs<sup>3</sup>.

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## II. HISTORICAL CONTEXT

Efforts to provide professionally-guided mental health services for children and adolescents date to the late 19<sup>th</sup> century, initially focused on “Wayward Youth” who were involved with the legal system. In the early 20<sup>th</sup> century, progressive social policy efforts led to the child guidance movement that 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 increasing role for pediatric psychopharmacology to complement psychosocial approaches to treatment.<sup>4</sup>

In the past four decades, the federal commitment to children’s mental health has been guided by an evolving array of values and principles initially titled as the “Child & Adolescent Service Systems Program” (CASSP) and more recently termed “System of Care” (SOC) values and principles that consist of contextual and ecological values and practices that prioritize family-driven, youth guided, coordinated care that is data driven, strength-based, individualized and culturally sensitive (see Appendix II).<sup>5</sup>

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
- implementation of systems of care for children and families based on SOC 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.<sup>6,7,8</sup>

## MISSION

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 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.<sup>9</sup>

## III. VALUES

System of Care (SOC) Values and Principles have been the driving policy force in public mental health for children since their initial elaboration under the aegis of the National Institute of Mental Health (NIMH).<sup>3</sup> Coupled with the advancing scientific base of clinical practice, SOC Values and 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 21<sup>st</sup> century.<sup>5</sup>

The System of Care approach incorporates:<sup>5</sup>

- a bio-psychosocial perspective
- a developmental approach

- family-driven, youth-guided care
- concepts of recovery and resiliency
- advocacy for family empowerment
- strengths-based approaches
- interdisciplinary collaboration
- multi-agency coordination
- continuity of care
- cultural considerations
- prevention and early intervention
- support for transition to adulthood
- evidence-based treatments and measurement of outcomes

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.<sup>10</sup> See also the AACAP policy statement on “Family and Youth Participation in Clinical Decision-Making”.<sup>11</sup>

Child-adolescent psychiatric trainees need to become proficient in their application of their evolving professional skill set within the context of SOC-guided programs and services.<sup>12</sup>

#### **IV. TARGET POPULATIONS: Children and adolescents with DSM disorders or are at risk of same, including children and adolescents who have experienced trauma or other Adverse Childhood Experiences**

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 disabilities, substance abuse services). In particular, integrating pediatric behavioral health care with physical health care has received increasing emphasis.<sup>13</sup>

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 that has lasted a year or more or that is expected to last that long in the absence of treatment is a required criterion for the designation of SED.<sup>14</sup> 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.<sup>15</sup>

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.

There is increasing awareness of how important trauma and adverse childhood experiences (ACES) are in increasing a child’s risk to develop a mental health or physical health diagnosis. ACES include childhood experience of violence or abuse,

witnessing violence in the home or community, having a family member attempt or die by suicide, parental substance use, parental mental health problems, parental separation, and parental incarceration. An extensive body of literature documents that adverse childhood experiences (ACES) are associated with a significant increase in the likelihood of a child or adolescent developing depression, anxiety, PTSD, suicide, and/or a substance use disorder. Multiple ACES are commonly experienced in childhood, with approximately 16% of all adults reporting a history of 4 or more ACES. Females and people of racial or ethnic minorities are overrepresented among those who experienced 4 or more ACES. ACES also increase the risk of a variety of physical health conditions including obesity, COPD, heart disease, cancer, diabetes, and unsafe sex as well as educational and employment difficulties. Many states participate in the federally sponsored Behavioral Risk Factor Surveillance System (BRFSS) to monitor the prevalence of ACES over time.<sup>17</sup>

When treating children and adolescents who have experienced trauma, it is important to adopt the practice of trauma-informed care, sometimes called trauma-informed approach, that recognizes the pervasiveness of trauma, and can help both support recovery and minimize risk of the care inadvertently re-traumatizing the child, for example as can happen when a child's mental health condition necessitates removal from the home.<sup>18</sup>

With the expansion of mental health capacity and with growing acceptance of the value of early recognition and treatment, public mental health systems are paying 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.<sup>19</sup>
- Early Childhood Populations: Early intervention mental health programming for at-risk preschool children (ages 3 to 5 years), as well as, consultative services for younger children (ages 0-3 years) are increasingly common.<sup>20, 21</sup>

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.

In the circumstance of situations of acute danger to life that would constitute commitment in an adult patient, parents who refuse voluntary admission of the child in general should be considered to be exercising neglect of the child's medical/psychiatric needs and the state's child welfare agency should be engaged in addition to hospitalization of the child.

## V. SERVICE ARRAY: THE EVOLVING CONTINUUM OF CARE

The array of services provided in 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 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<sup>22</sup> with an increasing:

- focus on home and community-based services as opposed to out-of-home care,
- provision of intensive services in less restrictive settings,
- coordination with other child-serving agencies (e.g., education, child welfare, juvenile justice, substance abuse, developmental disability). Wraparound service planning, aka Intensive Care Coordination, is a carefully defined process that supports effective care coordination.<sup>23, 24</sup>
- utilization of support for recovery provided by peer supports who have “lived experience” as parents and/or as patients who resemble the population served and promote engagement of the youth and family with treatment planning and delivery.
- recruitment of “natural supports” that exist in the community such as extended family, faith-based organizations, and other community organizations that are universally available such as youth centers and organizations such as the YMCA.

Examples of System of Care service programs with a service array that is expanded from a more traditional list include<sup>25</sup>

- In-home individual and family therapies
- Mobile crisis intervention services that can evaluate youth in crisis in their natural settings: homes, schools, or communities
- 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 or children receiving preschool child care
- School-based services, e.g. counseling, interdisciplinary team treatment; intensive day treatment services offered within the schools
- Respite care
- Family Partners for advocacy and other supports to parents
- Peer Mentors for skill building and other supports to youth
- Recreational services

- Family resource centers
- Self-help or Support groups, including those offered by family organizations
- Transportation
- Tutoring
- Legal assistance
- Housing assistance
- Vocational counseling
- Supports for independent living for youth transitioning to adulthood

## VI. TOOLS AND PARADIGMS OF PRACTICE IN MENTAL HEALTH

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:** Biopsychosocial 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. In traditional care, goals and priorities for intervention are primarily recommended and decided by professional providers, along a more traditional medical treatment model that is deficit-based and professionally driven.
3. **Interdisciplinary Teams:** Services are provided by an interdisciplinary clinical team.
  - In a simple situation, the team may include the child and parent(s) and a lead clinician as direct participants.
  - In more complex cases, the interdisciplinary team may be quite large including an array of professionals from involved systems including primary care, education, mental health, child welfare, juvenile justice and developmental disabilities
  - 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-based training programs collaborate in educating future clinicians.
5. **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.<sup>28,29</sup>

**B. System of Care Practice Concepts/Elements:** SOC Values and Principles provide direction for system development.

1. **New Roles for the Family:** Family voice and choice to identify and prioritize needs as well as future vision at the family level is emphasized. Youth and parent involvement at the system level regarding policy is equally emphasized. "Voice and choice", "Nothing about us without us", and No shame, no blame"<sup>30</sup> reflect the emphasis on a family-driven, youth-guided treatment process.

2. Community-Based Services: Service delivery in naturalistic community settings is supported. A broader array of service interventions is available.
  - a. Settings 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).
3. 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.<sup>30</sup>
  - b. Juvenile Justice: 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. 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<sup>31</sup>
    - a. 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.<sup>16</sup>
    - d. 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.
    - e. Developmental Disabilities: Developmentally disabled children have contact with the mental health system in consequence of their vulnerability to behavioral and mental health disorders.
    - f. Primary Care: Consultation with pediatric primary and specialty medical care providers and institutions aids in the arenas of access, identification, and aftercare.
    - g. Early Childhood: Efforts in support of early recognition, formal assessment and strategic clinical intervention are increasing.
4. 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. SAMHSA's Center for Mental Health Services has defined an approach, Building Bridges Initiative, to operationalize implementation of SOC values and principles into institutional care settings 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.<sup>32</sup>
5. New Technologies: As in other arenas, mental health practices are being shaped by evolving technologies, with both telepsychiatry and electronic health records (EHR) being utilized with increasing frequency by mental health systems. These technologies as well as web-based treatment resources offer opportunities to address concerns about quality improvement and access to care.

## VII. CHILD/ADOLESCENT PSYCHIATRISTS IN 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.<sup>19</sup>

Regardless of the specific roles assumed by a child/adolescent psychiatrist in a mental health setting, he/she needs to assert and retain leadership as the physician with oversight role of psychiatric and physical health aspects of care.

### Service Role Opportunities for Child/Adolescent Psychiatrists:

1. Providing psychiatric assessment and evaluation of the child.<sup>33</sup>
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.<sup>34</sup>
6. Consulting to a mental health system or to another child-serving system.
7. Performing forensic evaluations.
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 Mental Health Settings:

1. The CAP needs to know about mental health system laws and policies, 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 family-driven and youth-guided care a core value of the SOC philosophy.
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 how SOC values and principles apply across all of the child serving 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. CAPs should become involved at the systems level regarding advocacy and development of policies.

## VIII. 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 State and local mental health authority and commercial insurance oversight entity.

- 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.
- For-profit and not for profit organizations increasingly provide services supported by either public sector funding or via commercial insurance companies
- 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
- in the form of grants for specific sub-populations.
- as part of a population health approach such as an Accountable Care Organization, as supported through the Affordable Care Act of 2010<sup>35</sup>

Access to care is regulated in various ways:

- Increased access to clinically informed and evidence-based care has been supported by several federal statutes over the past 10+ years.
  - The Mental Health Parity and Addiction Equity Act of 2008 requires insurance groups offering coverage for mental health or substance use disorders to make these benefits comparable to general medical coverage, including deductibles, copays, treatment limitations, etc. The federal law has been further strengthened in similar parity laws in some states.<sup>36</sup>
  - The Affordable Care Act of 2010 increased the availability of private insurance coverage to people with mental health challenges or substance use disorders.<sup>37</sup>
  - The 21<sup>st</sup> Century Cures Act of 2016 supported the creation of new federal infrastructure to support clinically informed and measurement based care delivery that is specific to behavioral health disorders.<sup>38</sup>
- Some services are paid for regardless of who accesses them (e.g., emergency services).
- Commercial insurance is available to many families through a parent’s employer as a benefit, most often with significant cost sharing with the employee in the form of a deductible amount that must be paid for by the employee before the insurance benefit can be accessed as well as by co-pays from the patient for mental health services

- received through the insurance plan.
- Higher cost, higher intensity programs (e.g., inpatient, day treatment, residential, case management) typically require greater illness severity and disability. A 2019 judgment in a class action lawsuit in California, *Wit vs United Behavioral Health (UBH)* requires, among other rulings, that benefit eligibility for behavioral services must be determined by a clinically informed assessment tool that is available to the public and not proprietary.<sup>39</sup> Because of the size of California and the fact that UBH is a major health care insurer across the United States, it is likely that this ruling in California will be applied to other states as well.
  - Some services are paid for regardless of who accesses them (e.g., emergency services).
  - Eligibility for Medicaid funding can be achieved through poverty status or disability status. Medicaid is available at additional cost as a secondary insurance to commercial insurance, to provide Medicaid supported services such as intensive home and community-based services not available through the person's commercial insurance
  - 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 and supports:** Many communities rely heavily upon other providers of mental health services and supports including:

- Pediatric primary care providers increasingly provide screening and treatment to youth with common, relatively uncomplicated mental health problems, ideally with back-up support from and in collaboration with licensed mental health professionals.
- Private sector professionals who care for individuals covered by those able to pay privately.
- The National Families for Children's Mental Health has state and county-based chapters offer peer to peer support in a variety of ways including "peer support specialists" for parents and youth, as well as peer support groups for youth, parents and grandparents/other caregivers.<sup>40</sup> There are also other independent family organizations that are active in local communities, and counties
- The Family Run Executive Director Leadership Association (FREDLA) is a national organization that helps family-run organizations and family leaders stay informed and updated on the latest information, training opportunities and other activities in the field, to support effective stewardship of family-run organizations.<sup>41</sup>
- Mental Health/Behavioral Health practices and professionals are increasingly embedded into other child serving systems such as Child Welfare, Early Childhood, Developmental Disabilities and Juvenile Justice, in addition to Physical Health Care.

## **IX. THE ROLE OF GOVERNMENT:**

Publicly and commercially insured 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). The federal government works in partnership with the states to address mental health. The federal role in mental health includes regulating systems and providers, protecting the rights of consumers, providing funding for services, and supporting research and innovation. As a major funding source for mental health services, the federal government establishes and enforces minimum standards that states can then expand upon.<sup>42</sup> SAMHSA's CMHS funds Children's Mental Health Initiative cooperative agreements to with States to support SOC implementation and funds Mental Health Block Grants 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 by promoting protocols for early diagnosis and for providing an expanded service array including intensive home and community based services for children receiving Medicaid insurance.<sup>43</sup>
- 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).
- Increasingly, mental health knowledge and services are being embedded into the federal laws that govern the funding of federal dollars for other child serving agencies, most notably Child Welfare. The Families First Preservation Act of 2018, reforms the federal child welfare financing streams, Title IV-E and Title IV-B of the Social Security Act, to provide services to families who are at risk of entering the child welfare system. The bill aims to prevent children from entering foster care by allowing federal reimbursement for mental health services, substance use treatment, and in-home parenting skill training. It also seeks to improve the well-being of children already in foster by incentivizing states to reduce placement of children in congregate care and the use of standardized mental health rating scales to measure progress when congregate care for children in foster care is utilized.<sup>44</sup>

### **B. STATE INVOLVEMENT**

States have significant authority in making decisions about their mental health systems. Therefore, mental health regulations and available services can look very different from state to state and even from county to county. State mental health systems must meet certain standards set by the federal government, but they are free to expand beyond what exists at the federal level and improve services, access, and protection for consumers. This freedom to experiment with new or innovative services and delivery

models allows states to individualize services to local conditions. This freedom also allows states to create improvements, not infrequently driven by class action law suits that can ultimately be translated across the country.<sup>45</sup>

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 and commercial 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. Funding for commercially insured mental health programs comes from premiums for commercial insurance coverage that are supported by employer and employee contributions. Private grants also support some mental health services. All told, the funding mechanisms are quite complex and vary across states and communities within states.

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 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.

## X. **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 National Federation of Families for Children's Mental Health, among 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 (e.g. AACAP, AAP, and APA) 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 similarly to remedy a violation in the EPSDT component of federal Medicaid law for Medicaid insured children and adolescents with SED. The Massachusetts legislature has recently extended the requirement that intensive home and community-based services be available for people with commercial insurance coverage, in addition to those insured through Medicaid.

**B. Accountability: 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.

California has been a leader in supporting use of evidence-based outcome measures for publicly funded outpatient mental health programs. Following a five-phase approach, the Pediatric Symptom Checklist was recommended for statewide use to track clinical outcomes.<sup>46</sup> 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.

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, AACAP has supported the development of the Child and Adolescent Service Intensity Instrument (CASII),<sup>47</sup> 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 (ECSII),<sup>48</sup> provides a similar algorithm appropriate to that age range.

## APPENDIX 1<sup>□</sup>

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:

IV.B.1.f) Systems-based Practice. Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

\* Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry.

[https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405\\_ChildAdolescentPsychiatry\\_2019\\_TCC.pdf?ver=2019-03-28-161025-277](https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405_ChildAdolescentPsychiatry_2019_TCC.pdf?ver=2019-03-28-161025-277). July 1, 2019.

## APPENDIX II

### SYSTEM OF CARE VALUES AND PRINCIPLES, UPDATED

#### 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 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 and intervention 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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  39. <http://www.the-national-council.org/MDI-wit-v-UBH-position-statement>
  40. <https://www.ffcmh.org>
  41. <https://www.fredla.org>
  42. <https://www.mhanational.org/federa,-and-state-role-mental-health>
  43. <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and->

[treatment/index.html](#)

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## WEB RESOURCES

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

System of Care  
<http://www.childcareta.acf.hhs.gov>

SAMHSA  
<http://mentalhealth.samhsa.gov/topics/explore/children/>  
<http://mentalhealth.samhsa.gov/publications/allpubs/CA-0013/default.asp>

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

Wraparound  
<http://www.nwi.pdx.edu>

Serious Emotional Disturbance  
[http://en.wikipedia.org/wiki/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/>





4. With the dissemination of SOC Values and Principles there has 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.



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.