Practice Parameter on Child and Adolescent Mental Health Care in Community Systems of Care

ABSTRACT

This parameter presents overarching principles and practices for child and adolescent mental health care in community systems of care. Community systems of care are defined broadly as comprising the wide array of child-serving agencies, programs, and practitioners (both public and private), in addition to natural community supports such as religious and consumer organizations. Recommended principles and practices are derived from the system-of-care approach to service delivery. Based on the principles of the Child and Adolescent Service System Program, this approach has had a major influence on community systems of care through extensive federally funded projects and initiatives. The system-of-care model emphasizes that care should be tailored to the individual needs and strengths of the child and family and provided in the most community-based and least restrictive setting that meets their needs. Families are included as partners in the clinical process and are also involved in program development and evaluation. Services are coordinated and integrated into a comprehensive care plan. This model can be practiced even in the absence of formal systems of care or protocols, with the individual clinician promoting interagency coordination and child and family collaboration. This parameter is written for a broad audience of mental health professionals, with special emphasis on the roles of child and adolescent psychiatrists in community systems of care. *J. Am. Acad. Child Adolesc. Psychiatry*, 2007;46(2):284–299. **Key Words:** community mental health, community-based systems of care, Child and Adolescent Service System Program, practice parameter, practice guideline.

All children function within multiple systems, usually including their families, schools, communities, and primary health care. Children experiencing emotional and behavioral problems require services from additional systems such as mental health, special education, developmental disabilities, child welfare, and juvenile justice. Care is optimal when systems are organized to coordinate and integrate these services. Coordination of services is essential for all children involved with more than one system, but it is even more important for the most disturbed children and adolescents with multiple agency involvement, whose care has historically been uncoordinated and fragmented. This parameter defines community systems of care broadly as comprising the panoply of child-serving agencies and programs (e.g., primary health care, education, child welfare, mental

health, developmental disabilities, juvenile justice, and substance abuse), in addition to natural community supports such as religious and consumer organizations. The parameter also discusses a specific service delivery model, generally referred to as the system-of-care model, based on the principles of the Child and Adolescent Service System Program (CASSP; Stroul and Friedman, 1986). This model was developed to coordinate and integrate care for children with complex mental health needs and to provide the child and his or her family individualized, culturally competent services in the community whenever clinically appropriate. The system-of-care model has had a major influence on community systems of care for children and adolescents through extensive federal funding of system-of-care demonstration projects across the nation.

This practice parameter presents an overarching set of principles and practices that are based conceptually on the system-of-care model and are broadly applicable to community-based practice. The parameter is not intended to duplicate other practice parameters on assessment and treatment and will therefore emphasize aspects of clinical practice that are particularly important in community systems of care. It is also not intended to duplicate parameters on specific areas of community-based practice, such as treatment of specific populations of children in the community (e.g., children in foster care) or mental health services in specific settings (e.g., school-based consultation, mental health in juvenile justice settings). Instead, it focuses on practices that are recommended across all populations and settings encompassed in community systems of care.

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

such as intensive home- or community-based interventions. Community-based practice may also include administrative consultation to local and state health and social services organizations.

This practice parameter was written on behalf of the American Academy of Child and Adolescent Psychiatry (AACAP) to provide clinical guidelines for child and adolescent psychiatrists working in community systems of care, but it has broad applicability to other mental health professionals. Thus, the term *clinician* is used to refer to any licensed mental health professional working in a system of care, and *child and adolescent psychiatrist* is used for discussion of issues specific to child and adolescent psychiatry.

METHODOLOGY

The list of references for this parameter was developed by searching *OVIDMedline*, *PubMed*, and *PSYCINFO*; by reviewing the bibliographies of book chapters, review articles, and relevant monographs; and by asking colleagues for suggested source materials. The searches conducted in May 2003 and June 2004 used the following text words: "systems of care," "community-based systems of care," "community mental health," and "child or adolescent." The search covered the period 1990 to 2004 and yielded about 150 references. Each of these references was reviewed and only the most relevant were included in this document. Important historical publications before 1990 were also included.

BRIEF HISTORY

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

under the auspices of the National Institute of Mental Health.

CASSP promoted the development of services delivery through a system-of-care approach, defined as a comprehensive spectrum of mental health and other services and supports organized into a coordinated network to meet the diverse and changing needs of children and adolescents with severe emotional disorders and their families (Stroul and Friedman, 1986). CASSP outlined core values and guiding principles for a system of care that has served as a template for child community mental health system development across the United States. The major emphases of the CASSP principles are (1) individualized care that is tailored to the individual needs and preferences of the child and family, (2) family inclusion at every level of the clinical process and system development, (3) collaboration between different child-serving agencies and integration of services across agencies, (4) provision of culturally competent services, and (5) to serve youths in their communities, or the least restrictive setting that meets their clinical needs through providing a continuum of formal treatment and community-based supports (e.g., respite, crisis shelter care, mentoring).

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

The system-of-care movement has been successful in providing new strategies for service delivery and financing. Questions remain about the effectiveness of such systems in relation to more traditional systems, which specific outcomes are most meaningful to measure in evaluating the model, and what the active ingredients are that produce desired outcomes. Conducting research in complex systems of care is challenging because of the difficulty of identifying comparison groups and the near impossibility of using randomized assignment because the model has been embraced nationally and to offer less would be perceived as unethical (Duchnowski et al., 2002).

Although in the Fort Bragg study a randomly assigned system-of-care group showed clinical and functional outcomes similar to those of the traditional services group (Bickman et al., 1997), positive findings have been reported in other studies. Attkisson et al. (1997) reported reduced group home and foster care expenditures in three California counties using system-of-care approaches as compared with three counties that used more traditional services. Rosenblatt (1998) reviewed results of 20 community-based system-of-care studies, concluding that there were improvements in most domains assessed, including clinical status, cost, and use of restrictive placements. The results of the multisite national evaluation of the Comprehensive Mental Health Services Program for Children and Their Families include improved child and family functioning, increased stability of living situation, and reduced cost of care when cost offsets in education, juvenile justice, child welfare, and general health are considered (Foster and Connor, 2005; Holden et al., 2003). In summary, the system-of-care model appears to be beneficial in reducing use of residential and out-of-state placements and achieving improvements in functional behavior in youths with severe emotional and behavioral disorders who are served in multiple systems (U.S. Department of Health and Human Services, 1999).

Whereas child and adolescent psychiatry occupied a central role in the early community-oriented child guidance centers, later there was a shift to individual-oriented practice. Child and adolescent psychiatry has more recently reengaged itself as a discipline in community systems of care, providing an opportunity for a broader scope of child and adolescent psychiatric practice. The

challenge that faces child and adolescent psychiatry is to integrate its developing clinical and scientific knowledge and skills base into those systems and to integrate CASSP system-of-care values into the practice of child and adolescent psychiatry (Pumariega and Winters, 2003; Pumariega et al., 2003).

DEFINITIONS AND CONCEPTS

Traditional definitions of *community child and adolescent mental health care* have been based on the practice setting or population served (e.g., practice in a community mental health agency, services for children in foster care). This parameter uses a conceptually based definition that is broader in scope and philosophical in orientation; in other words, that community mental health care can be practiced in any clinical or nonclinical setting through application of the CASSP principles.

The system-of-care approach was developed to address the needs of children and adolescents with *serious (or severe) emotional disturbance*. Federal and educational definitions stipulate that children with serious (or severe) emotional disturbance have a diagnosable mental, behavioral, or emotional disorder that has resulted in functional impairment that sufficiently interferes with or limits the child's role of functioning in family, school, or community activities (Kutash et al., 2005).

The *wraparound process* is an integrated assessment and planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes (Burns and Goldman, 1999). It focuses on child and family strengths; it is community based, culturally relevant, flexible, and coordinated across agencies; and provides unconditional care, which entails a commitment to doing what is needed over the long run rather than ejecting a child from service if the needs are not being met (VanDenBerg and Grealish, 1996).

Child and family teams are used in a wraparound process as the locus of service planning and decision making. They are composed of the child and his or her family and any other friends or family members chosen by the family as well as all of the mental health or other agency providers that are involved with the child. The family selects treatment objectives and drives the planning process.

Strengths-based describes a clinical approach or attitude in which the clinician recognizes and allies with the adaptive capacities of children and their families rather than primarily focusing on pathology. Strengths-based services are provided to enhance the child or family's adaptive strengths, build self-esteem, and provide opportunities for successful experiences (e.g., music lessons for a talented youngster with emotional problems).

Intensive home-based services are services such as counseling, skill building, and case management that are provided in the home of a child and his or her family to address an acute emotional or behavioral problem and/or family issue that puts the child at risk for an out-of-home placement.

Mentoring services are provided by a trained adult who develops a relationship (preferably long term) with the child consisting of regular contacts in which the child and mentor are engaged in normative social and recreational activities.

Respite services provide care in the home or outside the home for a child with a serious mental health or health disturbance to give the family relief from the strain of caring for the child.

Flexible funds can be spent to meet the individual needs of a child and family without regard to the categorical restrictions of a particular agency (i.e., list of services for which they will typically pay). Such funds are generally drawn from a pool of blended funds contributed to by collaborating agencies.

RECOMMENDATIONS

Each recommendation in this parameter is identified as falling into one of the following categories of endorsement, indicated by an abbreviation in brackets following the statement. These categories indicate the degree of importance or certainty of each recommendation.

[MS] *Minimal standards* are recommendations that are based on rigorous empirical evidence (e.g., randomized, controlled trials) and/or overwhelming clinical consensus. Minimal standards are expected to apply more than 95% of the time (i.e., in almost all cases).

[CG] *Clinical guidelines* are recommendations that are based on empirical evidence and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time (i.e., in most cases). These practices should almost always be considered by the clinician,

but there are significant exceptions to their universal application.

[OP] *Options* are practices that are acceptable, but there may be insufficient empirical evidence and/or clinical consensus to support recommending these practices as minimal standards or clinical guidelines.

[NE] *Not endorsed* refers to practices that are known to be ineffective or contraindicated.

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 [MS].

Evaluating the child in the context of his or her family, school, community, and culture is central to all child and adolescent psychiatric assessment (AACAP, 1995). For most children this entails at minimum gathering information about the child's family, school functioning, and medical history. Children with serious emotional disturbance who are served in community systems of care have been shown to have high rates of comorbidity, psychosocial adversity, and involvement with multiple agencies, and they are at highest risk for placement in restrictive settings (Costello et al., 1996; Mattison et al., 1993). In such cases, clinical assessment requires an even more comprehensive approach and should incorporate a broad social ecological framework, taking into account a multiplicity of environmental and systems factors (Henggeler et al., 2001; Pumariega and Winters, 2003; Woolston et al., 1998). The social ecological perspective (Bronfenbrenner, 1979) views the child as embedded within interconnected systems, including the family system (and the extended family) and the extrafamilial systems, such as school, work, peers, primary health care, and the larger community, and cultural institutions that are part of the child and family's life experience, such as religious institutions. Systemic issues (e.g., legal, social, financial) that affect care are also part of the child's ecological system.

Ecologically targeted interventions may involve addressing barriers to care (e.g., providing home-based services or transporting the child to appointments) or accessing strengths and resources in the child's natural environment that can promote positive change. For example, identification of a helpful adult who is already present in the child's natural environment and may become a formal mentor or provide part-time employment can be a potent intervention.

Because children are involved in many systems, it is essential that adequate time be allotted in the evaluative process to gather ancillary data and communicate with other providers, in addition to having adequate time to interview the child and family.

Recommendation 2. The Clinician Should Develop Collaborative and Strengths-Based Relationships With Families, Emphasizing Partnerships at Both the Case-Planning and System-Planning Levels [MS].

One of the most important contributions in the past 2 decades of system of care reform has been the growth of the family advocacy movement, which has increased the collaboration among family members, clinicians, and program planners. Family advocacy organizations have taken a leadership role in mental health advocacy, system planning, quality improvement, program evaluation, parent education, and development of parent mentoring programs (Friesen and Stephens, 1998). The development of partnerships with families has been associated with a shift from conceptualizing the family as the source of (or significant contributor to) the child's pathology, to collaborating with parents, other family members, and parent advocates as partners in treatment. The parents' knowledge of their child, family, and culture is seen as equal in importance to the clinicians' knowledge of child development and psychopathology.

At the case-planning level, a climate of partnership between family members and clinicians in which the family's strengths are recognized facilitates an effective child and family team process (see Definitions) and allows family members to assume the natural functions of case management and self-advocacy. The family drives the team process by defining the desired outcomes and selecting individuals to add to the team. The team's function is to help identify how to best support the needs of the child and family through development of an individualized service plan. The child and family team should promote a climate of collaboration, respect, and trust. Collaboration is enhanced by having regular meetings. Such family-centered approaches have been recognized as improving the quality of care and contributing to increased

consumer satisfaction (Friesen and Stephens, 1998). An example was a parent with several special-needs children who was spending her entire week at appointments recommended by multiple providers who had never communicated with one another. On noting repeatedly missed appointments, one of the clinicians suggested convening a child and family team meeting. At the meeting the parent's accomplishments in caring for her children were acknowledged. She was able to share the burden of this situation and felt supported in her requests that the number of appointments be reduced.

Recommendation 3. Mental Health Interventions Should Be Actively Coordinated With Services by Other Providers, Including Primary Care Providers, and, Whenever Possible, Integrated With Interventions Provided by Other Social Agencies (This Can Occur at the Case, Program, and Larger Systems Levels [MS].

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

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

At the program level, the clinician can facilitate collaboration within a program by enlisting the participation of colleagues in clinical and policy decision making. At the system level, the clinician can promote integration and collaboration by advocating for interagency structures and agreements, which may include sitting on an interagency collaborative council. Such activities are enhanced by familiarity with the philosophies, mandates, and financial and organizational structures of the different child-serving agencies. These characteristics have an impact on the agency's ability to collaborate at the case and system levels. Availability to provide mental health consultation to primary care providers is another critical element in promoting collaboration and integration of care.

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

Increased service integration presents both opportunities and challenges in the area of patient information and confidentiality. Information sharing across service providers in the case of multiagency-involved youth is essential to effective service coordination. Organized systems of care have the potential to create informational databases that can be readily accessed in crisis situations. However, increased information sharing requires a heightened sensitivity that these are privileged documents, and the clinician should participate in safeguarding them against potential misuse. The clinician must also

comply with state confidentiality requirements, which may vary across states, and the federal Health Insurance Portability and Accountability Act.

Recommendation 4. Services Should Be Culturally Competent and Should Address the Needs of Underserved, Culturally Diverse, At-Risk Populations [MS].

More than 36% of all children and adolescents in the United States are from diverse, non-European racial and ethnic backgrounds, and this figure is expected to rise to more than 50% by 2030. In some communities, the non-European population is already a majority and clinicians should be sensitive to the local and regional differences in racial and ethnic composition. Children and adolescents from non-European backgrounds and their families face many disadvantages, including socioeconomic and educational disparities, language barriers, social discrimination, and lesser opportunities. Their cultures are distinctly different from those of European origins, with different beliefs, values, normative expectations for development and adaptive behaviors, parenting practices, relationship and family patterns, symptomatic expressions of distress, and explanations of mental illness (Pumariega, 2003). As a result of these differences, children from diverse cultures and their families have many specific mental health needs relevant to assessment, treatment approaches and modalities, and support services. Unfortunately, the failure to meet such needs has contributed to increasing mental health disparities in these already vulnerable populations. Studies support the presence of significant racial and ethnic disparities in a number of areas relating to children's mental health, including access to community-based services, accurate diagnostic assessment, access to evidence-based interventions, increasing rates of various forms of psychopathology in some populations, and significantly higher rates of out-of-home placements and institutiojustice [Pumariega, 2003; U.S. Department of Health and Human Services, 2001]). In addition, there is evidence of subtle differences in the metabolism of psychopharmacological agents in diverse populations, related to both genetic and environmental (e.g., dietary) factors (U.S. Department of Health and Human Services, 1999).

Children's mental health services should be provided within the cultural competence model. This model indicates the need to identify and address the special mental health needs of diverse populations through both clinician-related factors (e.g., acquiring knowledge, skills, and attitudes that enable them to serve populations different from their own) and system factors (e.g., reviewing and changing policies and practices that present barriers to diverse populations, staff training around cultural competence, and recruiting diverse staff and clinicians for planning service pathways and delivering care). This model also calls for the use of natural strengths and resources in concert with professional services that are protective and support children and families in diverse communities and cultures dealing with emotional disturbance. It also includes the adoption of culturally specific therapeutic modalities (e.g., use of native healers or cultural mediators), ethnopsychopharmacology practices, and the appropriate use of language interpreters (Pumariega, 2003).

The cultural competence model has been operationalized in consensus health and mental health cultural competence standards, such as the CMHS standards (CMHS, 1999), the Office of Minority Health (2001) Cultural and Linguistic Standards, and state-specific standards such as the State of California Cultural Competence Standards (1997). These standards address cultural adaptations and modifications in clinical processes (e.g., assessment, treatment planning, case management, linguistic support) and system processes (e.g., staff training and development, access protocols, governance of service systems, quality assurance and improvement, information management). The evidence is beginning to mount that adopting such practices results in improved access to services and retention in treatment (Pumariega et al., 2005).

Recommendation 5. To Achieve Individualization of Care for Children With Significant and Complex Mental Health Needs, Clinicians Should Consider a Wraparound Planning Process [CG].

Wraparound is an integrated assessment and planning process that knits together services from all of the involved providers to address the strengths and needs of the child and family (see Definitions). It is most effectively applied in an organized system of care in which the locus of service planning is the child and family team with an assigned care coordinator, and in which providers are encouraged to devote time to attending interagency meetings.

Even in less developed or organized systems, however, elements and principles of this process can be incorporated. For example, use of a strengths-based orientation and discussion of needs rather than problems promotes more active engagement of families in services planning activities. Team members can think strategically about how to use system resources most effectively to meet the individual child and family's needs in multiple domains (e.g., social, educational, family support, recreational, financial). The complementary contributions of various team members can work synergistically to promote better outcomes. The wraparound process should be guided by a comprehensive clinical assessment specifically addressing diagnostic and treatment issues (Solnit et al., 1997).

Interventions should be designed to reinforce strengths of the child and family. For example, a youth at risk for substance abuse may receive funding for prosocial activities such as horseback riding lessons or a health club membership to decrease the risk of association with substance-using peers. Strengths-based approaches may include nontraditional therapies such as community-based skills training or mentored work experiences that remediate or offset deficits. For example, a youth may be given a mentored job experience in a family restaurant in which the restaurant owners' adult son can coach him in developing more positive social behaviors. These interventions generally are not included in traditional categorical mental health funding and may require flexible funds (see Definitions) that are not assigned to specific services types. Because so many youngsters in community systems of care are receiving Medicaid, increasing the flexibility within this system needs to be addressed through appropriate legislative channels.

Through providing a balance of formal services and family and community supports, wraparound plans can build a level of service intensity rivaling that of inpatient or residential settings, without removing a child from the home. This is one of the primary goals of the system-of-care model because it allows the child to maintain continuity of family relationships and for family or environmental factors to be addressed. A number of studies of the wraparound process in different communities with diverse populations of at-risk children and families have reported positive outcomes in terms of reduction of externalizing behavioral problems, level of function, reduction in out-of-home placement, improved family management skills and function, and consumer/family satisfaction (Burchard et al., 2002; Kamradt and Meyers, 1999). The wraparound approach is best suited for children and their families with complex mental health and related needs who have not benefited from traditional services. Recent studies on the efficacy of wraparound have incorporated measures such as the Wraparound Fidelity Index to ensure fidelity to the model (Bruns et al., 2004).

Recommendation 6. Treatment Planning in Systems of Care Should Incorporate Effective Interventions Supported by the Available Evidence Base [MS].

The wraparound planning process alone may not be effective if the specific interventions themselves are not effective or if the skills and training of clinicians providing the care are not adequate. Therefore, interventions with the strongest evidence base should be prioritized in treatment planning and system design. Evidence-based interventions such as cognitive-behavioral, interpersonal, and other therapies for specific disorders should be incorporated (American Academy of Child and Adolescent Psychiatry, 2007; McClellan and Werry, 2003) when possible, as well as evidence-based community-based interventions (Burns and Hoagwood, 2002). The highest level of evidence (i.e., based on randomized, controlled trials), however, is not always available for children with significant comorbidity and psychosocial adversity (Hoagwood et al., 2001). Therefore, the clinician may rely on other types of evidence, for example, less rigorous studies, national consensus on best practices, or the standard of care in his or her community.

One of the most evidence-based, community-based interventions is multisystemic therapy (MST), an intensive, home-based wraparound model that combines a variety of individual and family interventions within a systemic context. MST has been evaluated with youth at risk for detention/incarceration and at risk for psychiatric or substance abuse hospitalization, with significant results in reducing out-of-home placement, reducing externalizing problem behaviors, reducing rates of recidivism, and lowering costs of treatment (Henggeler et al., 2001; 2003). The recent Surgeon General's reports on mental health (1999) and on youth violence (2001) point to research evidence supporting the effectiveness of a number of other

community-based interventions for children and youths such as intensive case management, therapeutic foster care, partial hospitalization, and intensive in-home interventions. Other community-based interventions that show promise include school-based interventions, mentoring programs, family education and support, crisis mobile outreach teams, culturally appropriate family support services, and time-limited hospitalization with coordinated community services (Burns and Hoagwood, 2002; Rogers, 2003; U.S. Department of Health and Human Services, 1999).

Training in evidence-based interventions is often necessary to ensure adequate fidelity to the model tested and to achieve expected outcomes. When collaborating with a team in which appropriate evidence-based practices are not being used or providers are deviating from standard practice, the clinician should offer to provide education if knowledgeable in those interventions or identify sources for appropriate training. If the risks of continuing such treatments are deemed significant, then it may be necessary to request a formal review using appropriate organizational mechanisms.

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 [CG].

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

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

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

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 [MS].

Growing awareness of the potential benefits and risks of pharmacotherapy for children and adolescents has led to increased emphasis on the psychopharmacological role of the child and adolescent psychiatrist in community systems of care. This role is an important one, especially as newer and potentially more effective pharmacological agents continue to emerge. However, the biopsychosocial knowledge and skills of the child

and adolescent psychiatrist are used most effectively as an integral part of the ongoing assessment and treatment process. Ongoing management may be provided by the child and adolescent psychiatrist, or the child and adolescent psychiatrist may function as a consultant. Systems of care should promote the full integration of prescribing practitioners into interdisciplinary teams and integrate pharmacological therapies into children's overall wraparound plans. This should include systematic assessment of target symptoms, behaviors, function, and adverse effects by the whole team (including both positive and negative side effects and such issues as optimal administration and dosing schedules). The team should also participate in the assessment of the efficacy of medications and interactions between pharmacotherapy and other treatment modalities and strengths-based activities. Pharmacotherapy in systems of care should focus on functional improvement as well as on symptomatic relief. It should also include collaboration and psychiatric consultation around medication management with other medical professionals prescribing either psychotropic or nonpsychotropic medications (Pumariega and Fallon, 2003).

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

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

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

Recommendation 9. The Clinician Should Be Familiar With the 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 [CG].

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

processes and outcomes. They should also be familiar with quality assurance and improvement processes, including the evaluation of clinical and system outcomes and evaluation of consumer satisfaction.

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

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

There are AACAP guidelines that can be helpful in advocacy efforts, including policy documents on system-of-care design, outcome measurement, and training for system-of-care practice (American Academy of Child and Adolescent Psychiatry, 1996a,b; 1998).

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 [CG].

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

The system-of-care model entails accountability of the system for outcomes, also recognizing that functional outcomes may be as important to families as symptomatic improvement. Although the clinician, the child, and the family share accountability for outcomes in an optimal treatment relationship, this is not always realistic or appropriate. In community systems of care, children and families who do not believe they are benefiting from services may either drop out or not comply with treatment recommendations. In the past, poor outcomes were blamed on family resistance or noncompliance, and such families were dropped from treatment. Under these circumstances, the clinician should identify what needs to be done differently to meet the needs of the child and family. A child or family dropping out of service should trigger review of the treatment plan rather than discharge from care. Different strategies may include offering home-based services or offering more culturally competent services. Setting different target goals for treatment or shifting the focus to functional issues that are more important to the child's parents may also be required.

Families and consumers have taken a more active role in some systems of care in developing outcome

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

Recommendation 11. Services Should Be Delivered in the Most Normative and Least Restrictive Setting That Is Clinically Appropriate. Children Should Have Access to a Continuum of Care With Assignment of Level or Intensity of Care Determined by Clinically Informed Decision-Making [MS].

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

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

There are some situations, however, in which restrictive placements are necessary and beneficial and should be available. Specific indications include acute suicidality or psychosis, violent behavior, or serious sex-offending disorders requiring safety and containment (American Academy of Child and Adolescent Psychiatry, 1989).

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 [CG].

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

There is a need for programmatic support and adequate funding for these transitions. For example, in transitioning from residential treatment to outpatient services, there may be a break in services before a new clinician is assigned. In such cases, the residential treatment center should provide services and care coordination during the transition period and be proactive before discharge in setting up the outpatient plan. A break in continuity may also occur when a youth enters a juvenile justice setting and may lose needed mental health services and important clinical information unless there is adequate communication and opportunity for mental health treatment in that setting. It is also important to involve the school in the planning process before a youth leaves a treatment center. In all cases, the parents and child should be involved in decision making around these transitions in care. In general, the treating program should be responsible for the child and the transition plan until the child officially transitions to the new treatment setting.

The system of care should prioritize continuity of care whenever possible if the intervention is working, including situations in which funding considerations may mandate a switch of providers. This is especially true for primary health care because children benefit from a long-term relationship with one primary care provider. During transitions, continuity should be maintained through communicating and transmitting information, ongoing coordination of care, and continuing a particularly effective service during the transition period. For example, some systems will allow a child to continue seeing a long-standing individual therapist periodically during placement in residential treatment to avoid an interruption in that relationship. Clinicians should advocate in their systems of care for prioritization of continuity of care, assigned responsibility during transitions, and reimbursement mechanisms to support these functions.

Recommendation 13. Systems of Care Should Incorporate Prevention Strategies in Clinical Practice and System Design [CG].

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

Systems of care bear responsibility to assign some of their resources to prevention efforts. These may include such activities as screening young children for mental health or developmental problems in primary care settings, providing mental health consultation to Head Start, early intervention, and other child care settings; providing mental health services to adults whose children are at risk for out-of-home placement; and providing consultation to primary care providers. One potential barrier to young children and their families receiving mental health services is that an infant or toddler may not yet meet the full *DSM-IV-TR* criteria for a mental health diagnosis (or one that is reimbursed). Several potential remedies exist. First, the state and local funding agencies can adopt alternative eligibility criteria for services or have contractual agreements with other child-serving agencies that do not require formal diagnosis. For young children who are already showing some early symptoms of a psychiatric disorder, use of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R; Zero to Three Diagnostic Classification, 2005) is more likely to identify conditions that make them eligible for services because the diagnostic criteria are more developmentally appropriate. Some states use "crosswalks" to translate DC: 0-3R diagnoses into ICD-9 codes, which are still required for Medicaid and other reimbursement systems.

Clinicians can incorporate prevention efforts in their clinical practice by helping to identify vulnerable or at-risk young children (as well as older children and adolescents) who may benefit from preventive services.

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

SCIENTIFIC DATA AND CLINICAL CONSENSUS

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

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Role of Pediatric Health Care Professionals in the Provision of Parenting Advice: A Qualitative Study With Mothers From 4 Minority Ethnocultural Groups Thyde M. Dumont-Mathieu, MD, MPH, Bruce A. Bernstein, PhD, Paul H. Dworkin, MD, Lee M. Pachter, DO

Objective: This study's aim was to elicit the perspectives of minority parents on their expectations of pediatric health care providers as a source of advice on "raising their child" and whether they would seek advice from these providers. A secondary aim was to demonstrate the value of qualitative methods for assessing parental attitudes in pediatric research. *Methods:* Mothers with children between 3 and 12 years of age who identified themselves as African American, Jamaican, Haitian, or Puerto Rican were recruited from community sites. Audiotaped focus groups were conducted by trained moderators using an interview guide, to obtain the perspectives of the participants regarding the role of pediatric providers in the provision of parenting advice. *Results:* Ninety-one mothers participated in a total of 20 focus groups, with 4 to 6 discussions per ethnocultural group. The focus groups revealed that, in general, parents do not look to child health care providers for advice on raising their children. The identified themes emphasized the importance of the relationship between providers and families. A few parents had the type of relationship within which the pediatrician already functioned as a provider of parenting advice. Physicians were considered skilled in the maintenance of physical health. The parents expressed a desire to receive more anticipatory guidance on developmental and behavioral stages and milestones. Pediatricians also served specific administrative functions valued by parents. *Conclusions:* Minority parents of preschool-aged and school-aged children do not view the primary care provider's role as including the provision of parenting advice. Expectations must be modified to enable health care professionals to function effectively in the role of advisor regarding parenting issues. **Pediatrics** 2006;118:e839–e848.

Improving Pediatric Prevention via the Internet: A Randomized, Controlled Trial Dimitri A. Christakis, MD, MPH, Frederick J. Zimmerman, PhD, Frederick P. Rivara, MD, MPH, Beth Ebel, MD, MPH, MSc

Background: Innovations to improve the delivery of pediatric preventive care are needed. *Methods:* We enrolled children, 0 to 11 years of age, into a factorial, randomized, controlled trial of a tailored, evidence-based, Web site (My Healthy Child) that provided information on prevention topics before a scheduled well-child visit. There were 2 components of the intervention, namely, parental Web content and provider notification. Parental Web content provided information to parents about prevention topics; provider notification communicated to physicians topics that were of interest to parents. We assigned 887 children randomly to 4 groups (usual care, content only, content and notification, or notification only). Outcomes were determined with telephone follow-up surveys conducted 2 to 4 weeks after the visit. Poisson regression analysis was used to determine the independent effects of each intervention on the number of topics discussed and the number of preventive practices implemented. *Results:* Parents in the notification/content group and in the notification-only group reported discussing more My Healthy Child topics with their provider. Parents in the notification/content group and in the content-only group reported implementing more My Healthy Child topic suggestions (such as use of a safety device). *Conclusions:* A Web-based intervention can activate parents to discuss prevention topics with their child's provider. Delivery of tailored content can promote preventive practices. **Pediatrics** 2006;118:1157–1166.