Systems of Care in Children's Mental Health

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Severely Emotionally Disturbed (SED)

7 AAC 43.471. Severely emotionally disturbed children

- (a) A severely emotionally disturbed child must meet the following criteria:
- (1) the recipient's specific symptoms and maladaptive behavior are identified and documented in the clinical record through an intake assessment and functional assessment, and provide the basis for the recipient's diagnosis;
- (2) the recipient has, as a result of the recipient's symptoms and maladaptive behavior, serious functional impairment in one or more areas of social functioning, including family, school, or community, as indicated by
- (A) an Axis V Global Assessment of Functioning (GAF) rating at admission of 50 or less under the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision, dated 2000 (*DSM-IV-TR*), adopted by reference; or
- (B) the exhibition of specific mental, behavioral, or emotional disorders that place the recipient at imminent risk for out-of-home supervision or protective custody by state or local authorities;

Severely Emotionally Disturbed (SED)…

- (3) the clinical record confirms that the recipient's symptoms and maladaptive behavior have lasted at least six months, and the symptoms and maladaptive behavior require mental health rehabilitation services that are medically necessary, as determined in accordance with 7 AAC 43.486;
- (4) the recipient's symptoms and maladaptive behavior are not a result of intellectual, physical, or sensory deficits;
- (5) the recipient's treatment planning process requires active collaboration of the interdisciplinary team required under 7 AAC 43.470; and
- (6) the recipient's clinical record documents that the interdisciplinary team required under 7 AAC 43.470 has recommended and approved, in accordance with that section, the mental health clinic services and rehabilitation services specified in the individualized treatment plan.
- (b) In this section, "functional impairment" means a disorder that substantially interferes with or prevents a recipient from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. "Functional impairment" includes disorders of episodic, recurrent, or continuous duration. "Functional impairment" does not include temporary, expected responses to stressful events in the recipient's environment.

(Alaska Administrative Code 7 AAC 43.471 retrieved May 17, 2010 from http://www.touchngo.com/lglcntr/akstats/aac/title07/chapter043/section471.htm)

Brief History of Systems of Care

- 1969 – Joint Commission on Mental Health of Children determined that only a fraction of youth were receiving mental health services and that most services they were receiving were ineffective.
- 1982 – Jane Knitzer's *Unclaimed Children* and other reports found that, when youth *were* receiving services, that youth were often being served in overly restrictive settings; coordination between sectors serving children was weak; services were restricted to inpatient, outpatient, and residential treatment.
- 1984 – National Institute of Mental Health Launches the Child and Adolescent Service System Program (CASSP) to help states and communities "build their capacity to develop systems of care particularly targeted to children with serious and complex needs who were involved with multiple service sectors, for example, mental health, special education, child welfare, and juvenile justice " (Huang et al., 2005, p. 616).
- 1986 – System of Care approach & framework put forth by Stroul & Friedman

(Huang et al., 2005, p. 616).

System of Care Definitions

- A major accomplishment of CASSP was the development and definition of the concept of a system of care to serve as a framework for children's mental health reform (Stroul & Friedman in Huang et al., 2005, p. 616).
- Original system of care definition:
  - "comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet multiple and changing needs of children and families" (Stroul & Friedman, 1986, p. 3)
- Updated definition (2005):
  - "A system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth and families function better at home, in school, in the community and throughout life" (www.systemofcare.samhsa.gov cited in Stroul & Blau, 2008, p. 4).

Core Values of Systems of Care

- 1. The system of care should be child centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
  (go to: http://www.systemsofcare.samhsa.gov/headermenus/deffamilydriven.aspx)
- 2. The system of care should be community based, with the focus of services as well as management and decision-making responsibility resting at the community level.
- 3. The system of care should be culturally and linguistically competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
  (go to: http://www.systemsofcare.samhsa.gov/headermenus/culturalcompetence.aspx

(Stroul & Friedman, 1986, reprinted in Stroul & Blau, 2008, p.6)

Guiding Principles of Systems of Care

1. Children with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social, and educational needs.

2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.

3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.

Guiding Principles…

4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of planning and delivery of services.

5. Children with emotional disturbances should receive services that are integrated, with linkages between the child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.

6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

Guiding Principles…

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8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.

9. The rights of children with emotional disturbances should be protected, and the effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.

10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and needs.

(Stroul & Friedman, 1986, reprinted in Stroul & Blau, 2008, p.6)

Focus of System of Care Development

- Requires a multifaceted, multilevel process that involves making changes:
  - In state policies, financing mechanisms, workforce development, and other structures and processes to support systems of care
  - At the local system level to plan, implement, manage, and evaluate the system
  - At the services delivery level to provide a board array of effective, state-of-the-art treatment services and supports to children and families in an individualized and coordinated manner

(Stroul & Blau, 2008, p. 8)

System of Care Stakeholders

- Child and Family
  - Most imperative stakeholder with regard to identifying needs, goals, services, and supports needed to maintain youth in their community settings while also supporting families & caregivers.
- Mental Health Services
  - Community mental health providers, funders, and administrators that assist in coordinating the components of service delivery. In Alaska, mental health tends to be primary point of contact and brings system of care stakeholders to the table with the youth and family (this may differ in other states).
  - Residential and inpatient services provide the most restrictive setting for stabilization and the safety of children, their families, and the community as a whole. Therapeutic group homes and foster homes are also included in this category.
- Social Services
  - Family support services including: child protection/child welfare, financial assistance, respite care, shelter services, foster care, and adoption. These services are designed and implemented to help families with severely emotionally disturbed children stay intact.

System of Care Stakeholders…

- Educational Services
  - Provides insight into the needs of the child and family through the school system. Provides Individual Education Plans for academics as well as behavior. Schools can incorporate mental health treatment goals into IEPs and vice versa.
- Recreational Services
  - Designed to enhance children's overall well being by providing community based services that are guided by professional and natural helpers from the community and who also engage in the treatment planning process to enrich the child and family's natural supports and activities outside of the typical treatment setting.
- Juvenile Justice Services
  - Not involved in all systems of care or with all youth being served by systems of care. This stakeholder will engage with youth on probation or at risk of being placed on probation and/or incarcerated and will be in involved in the treatment process in order to address the increasingly complex needs of an individual youth and his/her family.

(Examples of stakeholders taken from "System of care framework" reprinted from Stroul & Friedman, 1986, in Stroul & Blau, 2008, p. 7).

Levels of Stakeholders

- Stakeholder is a term used to describe people and/or agencies interested in a common goal throughout the stages of implementation of the system of care.
- These stakeholders include people and agencies from federal, state, local, and service delivery levels (including the youth and their family) who are engaged in the various stages of development, implementation, and evaluation of a SOC

Experiential Exercise #1

- Imagine you are the parent of a three-year old child who has been asked to leave multiple daycare settings due to aggression toward adult staff and peers, often hits or bites other children when out in the community, has frequent tantrums, and struggles to communicate verbally. You have been concerned about your child's behavior for about a year but have seen the behaviors worsen since getting a divorce about four months ago. You don't know where to turn or what to do and finally seek assistance from your child's pediatrician, who then recommends that you seek mental health care for your child.

Directions :

At each station, review the available documents and pay attention to the similarities and differences. Be prepared to come back to the group and discuss thoughts, feelings, and comments you may have related to this process and the exercise.

Interagency Collaboration

- "Children and youth with emotional and behavioral challenges and their families depend on multiple agencies, providers, community supports, and funding entities, as well as their own internal resources. When one hand does not know what the other is doing, inefficiencies, frustration, and ultimately poor outcomes result at both the system and service levels. Building systems of care requires resources that span across agencies and among partners. Without collaboration, effective system building cannot occur" (Stroul & Blau, 2008, p. 98-99).

Definitions of Collaboration

- **Interagency collaboration**:
  "Interagency collaboration—the process of agencies joining together for the purpose of interdependent problem solving that focuses on improving services to children and families—represents a fundamental reform in the way services are provided for children with severe emotional disturbances and their families"
- **True collaboration**:
  "True collaboration is *successful* collaboration, as experienced by collaborative participants, that incorporates qualities of role clarity for families and service providers, interdependence and shared responsibility among collaborating partners, striving for vision-driven solutions and a focus on the whole child in the context of the child's family and community"

(Hodges, Nesman, & Hernandez, 1999, p. 17-18)

True Collaboration

- Difficult to achieve
- Creates/ "breeds" more collaboration
- "At the heart" of system of care
- Requires agencies to shift their thinking of the children they serve from "my children" to "our children"
- Requires shared decision making and responsibility among child serving agencies
- Focuses on what is best for individual children and families in the context of their community

(Hodges, Nesman, & Hernandez, 1999, p. 18)

Collaboration in SOC Research

- Collaboration is believed to be a "key ingredient and driving force in developing systems of care"
- Collaboration is needed at every level of development and implementation of a system of care:
  - National level
  - State level
  - Community level
  - Direct service level
- Collaboration at all levels is seen to "bolster increased parent and family demands for quality, accessibility and appropriate services, along with a push for consideration of the family's perspective in service planning and delivery"

(Hodges, Nesman, & Hernandez, 1999, p. 21-22)

Collaboration at Various Levels

- National Level
  - Develop initiatives that require new treatment strategies that include collaboration as a "necessary component"
- State Level
  - Policy-makers calling for interagency collaboration as a way to decrease spending and improve outcomes
- Community or Local Level
  - Change at this level can be driven by negative publicity and court orders that attempt to mandate better services for children and their families
  - Potential to benefit a greater array of children by developing awareness for and of the community's needs
  - Creates a common vision and comprehensive plan for local intervention
- Direct Service Level
  - "Programs are being created that attempt to overcome differences in service delivery strategies and philosophies by incorporating system of care philosophies into in-service and pre-service training"

(Hodges, Nesman, & Hernandez, 1999, p. 22)

6/14/2010 19

Related Actions & Strategies in SOC

- Planning and needs assessments
- System modifications to fit identified needs
- Technical assistance and training
- Constituency building
- Cost efficiency in achieving desired outcomes
- Improved advocacy for children's mental health
- Increased access & reduced barriers to services for youth and families
- Expansion of resources available to individual agencies through cooperative programming, enhancing staff skills, and sharing facilities

(Hodges, Nesman, & Hernandez, 1999, p. 22-23)

6/14/2010 20

Types of Collaboration

- Case-centered
  - Addresses needs of individual cases using case management and coordination
- Program-centered
  - Involves coordinating fragmented services into a comprehensive system
- Policy-centered
  - Meetings of representatives of various agencies that the state or national levels to "advise, plan, or recommend policy changes"

(Hodges, Nesman, & Hernandez, 1999, p. 27)

6/14/2010 21

Collaboration: Major Barriers

- Personal
  - Feelings of loss of power
  - American culture of competition and independence
  - Fear of losing funding, redefining job duties, loss of identify
  - Negative past experience
- Systemic
  - Limited resources such as "time, specialized staff, technology funding, and experience with collaboration"
  - Fears of threatened "ways of doing business and require staff time that takes away from their normal duties"
- Environmental
  - Racial or cultural polarization
  - Competing mandates
  - Insufficient resources
- Bureaucratic
  - Constraints that lead to maintaining the status quo, standard operating procedures, incentives, and supervisory control
  - Disciplinary lines that affect agency culture and staff role definitions

6/14/2010 (Hodges, Nesman, & Hernandez, 1999, p. 28-29) 22

Components of Successful Collaboration

- Shared goal or vision
- Speaking the same language
- Trust and commitment
- Maintaining autonomy
- Respect for diversity
- Clear roles and responsibilities
- Governing structure
- Personal choice
- Evaluation

(Hodges, Nesman, & Hernandez, 1999, p. 30-33)

6/14/2010 23

Interdependence

- Interactions between & among professionals whereby each is dependent on the other to accomplish tasks/goals
- Must have clear understanding of each professionals' role
- Interdisciplinary "team" can address complex problems
- Team members have strong professional identity

(Bronstein, 2003, p. 299-301)

6/14/2010 24

Newly Created Professional Activities

- Collaborative acts, programs, structures that can achieve more than professionals working independently of one another
- Creates changes in the way services are designed and delivered
- Can lead to reform that affects & is observable at all levels

(Bronstein, 2003, p. 300)

Flexibility

- Refers to deliberate occurrence of role-blurring
- Allows professionals to reach comprises & alter role as needed
- Successful collaboration requires adaptability
- Demands less hierarchal relationships
- Roles should be derived from training as well as needs of the situation, family, client, colleagues, organization, etc.

(Bronstein, 2003, p. 300-301).

Collective Ownership of Goals

- Shared responsibility about design, definition, development, and achievement of goals
- Each team member responsible for their own part in the success or failure of goals
- Must support constructive disagreement
- Greater inclusiveness in decision making leads to "a wider base of ownership of the process and increased support for implementation" (Abramson & Rosenthal in Bronstein, 2003, p. 301)
- Key aspect of social workers' socialization is increased involvement in team processes, inc. discussions and decisions

(Bronstein, 2003, p. 301-302)

Reflection on process

- Includes team members processing their working relationship and incorporating feedback to strengthen collaborative effectiveness
- Encourages intra-team conflicts to be addressed in order to increase communication & success
- Allows for the examination of ethical dilemmas and discussions about how to confront them

(Bronstein, 2003, p. 6)

Experiential Exercise #2

- Break up into small groups of and review the attached case study. Using the list of stakeholders that could potentially become a member of the treatment team for the identified child and his family, choose the stakeholder(s) that your group thinks would provide the most appropriate support using the system of care approach. Prepare to report back to the larger group to share about and discuss your choices.

Case Study for Experiential Exercise #2

- Robert is a four and half-year old Alaska Native male who currently lives with his biological mother and two older siblings (a seven-year old brother and nine-year old sister). Robert has been in OCS custody and has lived in relative placements off and on since he was two years old. He has been home with his family of origin for six months. Since his most recent return home, Robert has been exhibiting aggressive behaviors at home with his mom, siblings, and also in his day care setting. At day care, he has been sent home for biting and/or hitting his peers and staff an average of five times per month with a recent escalation to two times per week for the past month. Robert's mom, Sally, has been employed at the same job for the past nine months, has earned some leave time, and has generally been considered a reliable employee. However, she is beginning to run low on leave and her employer is becoming frustrated at the amount of time Sally takes off due to her child's behaviors and related needs.
- Sally has successfully worked her case plan with OCS and has regained physical custody of her children. OCS has limited contact with the family; however, Sally is able to use them as a resource for help and referrals when and if she needs assistance.
- Robert has a history of witnessing and experiencing domestic violence in his mother's home from infancy until age two and at times in relatives' homes over the years. Robert was initially removed from his mother's custody due to substantiated reports of harm filed on behalf of his older siblings who both were in elementary school. Initially, the most common report was that the children did not show up regularly for school and, if they were there, they were unkempt and often complained of not having enough food. Removal of Robert and his siblings occurred when the oldest reported that she was afraid to go home and did not want to leave the school. Upon investigation, it was found that there was an adult male living in the home who was frequently violent with both the children and their mother. After the removal, Robert and his siblings moved to an aunt's home for six months, then back to their mom's for three months before another report of domestic violence came to OCS from the Anchorage Police Department. The children were then placed with a different aunt and uncle for one month but were removed from this placement after domestic violence was reported and substantiated. Around this time, Robert began to show signs of aggressive behavior in the home and at day care. He was placed with his grandparents while the other two children went back to the first aunt's home. They remained in these placements until the recent return to their mother's care.
- Robert is able to communicate with caregivers by using rudimentary language skills and nonverbal communication. When he is with children his own age, he attempts to use the same communication skill set; however, he often gets frustrated with the children who do not understand him and will hit or call names. Due to his lack of verbal communication skills, Robert often isolates in social situations and has not learned the typical social skill set as his same-aged peers. Robert makes eye contact and engages with adults when they are patient and allow him to make the initial contact.
- There is no known sexual abuse in Robert's history.

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