

PUBLICATION SERIES

PA CASSP Training and Technical Assistance Institute

MAKING THE BEST CHOICE

Service Selection in Children's Mental Health

By Gordon R. Hodas, M.D.

a CASSP discussion paper

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PUBLICATION SERIES

Pennsylvania CASSP Training and Technical Assistance Institute

2001 N. Front St., Building 1, Suite 316

Harrisburg, PA 17102

Phone: (717) 232-3125; Fax (717) 232-3610; Website: <http://pacassp.psych.psu.edu>

Director: Marsali Hansen, Ph.D., ABPP

Publications Specialist: Harriet S. Bicksler, M.A.

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INTRODUCTION

Meeting the mental health needs of children up to age 21 with serious emotional disturbance (SED) is a challenging task for all who know and care about children. Given that the quality of life and well being of children are at stake, careful consideration of service selection is clearly indicated. Such consideration is especially relevant since the recent report by the Surgeon General on children's mental health services (2001) that identified gaps in service and access to service.

For our service system to be useful and dynamic, it is important that there be understanding of the scope, intended purpose, and implementation of all services within the array of mental health services for children in Pennsylvania. With this knowledge, practitioners and families can make truly individualized, informed decisions as to the most appropriate service or combination of services for children under their care. Understanding the service array also requires appreciation of possible differences in services within regions and counties and among providers. At a clinical level, there is need to understand the range of specific factors that may influence service selection, so that a good match can be made between child and family and the service or services ultimately selected.

In general, a service is authorized by a funding source when "medical necessity" is determined to be present. Medical necessity is significantly related to the severity of the child's SED, but there are additional considerations for a prescriber and team, beyond severity or degree of impairment, that often enter into determining the best service choice for a child and family. Determination of need also includes assessment, in collaboration with the family, of available supports for the child in the home and community. For example, the child with SED whose family and community have the capacity to effectively support and monitor him or her at home may be able to benefit more from a less restrictive service than another child with the same severity of impairment, whose family and community lack such capability. A "medically necessary" service is one that is needed to address the child's SED based on a level of need that remains after family strengths and community resources (the natural supports) have been fully identified and factored in. Thus, the presence of psychiatric

severity in a child consistent with a certain level of care (or with a certain intensity within a level of care) does not always signify that the child requires that level of care or service intensity.

For a prescriber and team, making the best service choice may go beyond considerations of medical necessity per se, even when broadly conceived. Other specific factors may enter into the decision of what service(s) to request for a particular child, especially when the child meets medical necessity for more than a single service or level of care. It is important that these less apparent factors be recognized, so that service selection can become an individualized process that is responsive to child and family need.

This paper takes all of these factors into consideration and provides useful approaches for making the best choice in service selection in children's mental health. We begin by describing three prerequisites for an informed service decision— *information, participation, and consensus*. Then, building on a recognition that the child's severity of impairment is a significant but not the only determinant of service selection, we consider a series of additional factors that also may influence service selection for an individual child. Next we consider each of the common children's mental health services within the array of services in Pennsylvania's public sector. We then discuss how an evaluator (hereafter referred to as the *prescriber*) and interagency service planning team (ISPT), when involved, can go about determining appropriate services for a particular child. Throughout the discussion, it is recognized that methodologies and guidelines represent only starting rather than ending points, since service selection becomes helpful only when the uniqueness of each child and family is genuinely understood and appreciated.

Finally, I have been greatly enriched over the years by conversations with families, providers, county and managed care representatives, OMHSAS staff, and others, and I am grateful for their support and suggestions. At the same time, this paper reflects a synthesis based on my own observations and learning and does not represent OMHSAS or any of my valued colleagues.

HOW TO USE THIS PAPER

This paper consists of three main parts:

- **An orienting section** that considers the prerequisites for an informed service decision and the range of factors, in addition to severity of impairment, that may justifiably influence service selection (pp. 5-11);
- **A discussion of each of the mental health services in Pennsylvania**, progressing from least to most restrictive, within the service array for children and adolescents in the public sector and their families (pp. 12-41); and
- **Guidelines for service selection** for evaluators and teams and general discussion regarding ways to improve the children's system (pp. 42-49).

A seasoned reader with long-standing experience in the children's system may choose to read the paper straight through in its entirety. Less experienced individuals may choose instead to read the first and third sections, in between skimming the discussion of specific services with special attention to those services of particular interest. The paper can then be used as a resource for future reference and review.

When reviewing the analysis of specific children's services (part 2), the reader is encouraged to refer periodically to the "Table of Mental Health Care for Children and Adolescents," prepared by the Office of Mental Health and Substance Abuse Services (see Appendix B). This table identifies mental health services for children and adolescents, distinguishing between services for the child who remains in a community/

family environment, and services for the child residing in an out-of-family environment (group home and host home CRR, RTF, and inpatient). Note that what the table identifies as least restrictive on the left side of the table under "health promotion and community integration" is in many cases similar to what in this paper is referred to as "natural supports," a concept that also includes the involvement of neighborhood and community resource persons and extended family.

In the discussion of specific services, an effort has been made to offer a balanced discussion that highlights both the strengths and limitations of the service in question. Individuals directly involved with a specific service may identify additional issues that are not addressed here. This is unavoidable, given limitations of both space and full awareness. The intention here is for this paper to serve as a catalyst for further discussion and planning rather than as a final word on the children's system in Pennsylvania. It is important that families, mental health providers, representatives of child serving systems other than mental health, and other stakeholders be informed about the entire array of children's mental health services, so that service selection identifies the best choice for each individual child and family. It is also important that those concerned with the well-being of children reflect on the strengths and limitations of the children's service system, so that gaps can be filled and needed improvements made. Understanding what we have can serve as a foundation for determining what we want to have, so that our collective efforts at change are effective.

PREREQUISITES FOR INFORMED SERVICE DECISIONS

There are three prerequisites—regardless of the presentation of the child—for informed service decisions: *information*, *participation*, and *consensus*. Taken together, these prerequisites are consistent with the Child and Adolescent Service System Program (CASSP) Principles that guide services in Pennsylvania (see Appendix A).

Information:

Service provision in the absence of adequate information is likely to be both ineffective and costly. Services are intrinsically neutral and may even be harmful, unless appropriately matched to the child’s strengths and needs and guided by a cohesive, integrated plan of action. Potential sources of information include the child, parents or guardians, extended family, teachers, community resource persons, and mental health and other child-serving representatives already familiar with the child. Information should be pursued in collaboration with the child and the child’s parents, with appropriate consents obtained to contact helping professionals and relevant individuals within the community.

When Behavioral Health Rehabilitation Services (BHRS) for children and adolescents or mental health residential treatment facility (RTF) services are being considered, the Department of Public Welfare has created specific procedural requirements intended to establish a broad database. In some counties under HealthChoices, managed care has extended this requirement to partial hospital programs. The requirements include a psychiatric or psychological evaluation (a psychiatric evaluation only, for JCAHO accredited RTFs) and the convening of an interagency service planning team (ISPT) meeting. The ISPT is a child and family team that meets with involved child-serving representatives to consider the child’s strengths and needs, determine desired outcomes, and review service options.

Comprehensively pursued, the psychiatric and psychological evaluation can be extremely informative, thereby increasing the likelihood of a match between the child’s needs and the services ultimately requested to meet the needs. One recommended protocol involves the “Life Domain Format for Psychiatric/Psychological Evaluations” (Hodas, 2001), which many counties have adopted. In like manner, a cohesive interagency team conducts team meetings that build on the prescriber’s evaluation, confirming and further refining appropriate service determination for the child. A major challenge in public sector children’s mental health in Pennsylvania involves

integrating the efforts of the prescriber and the team, so that their respective efforts are cohesive. In addition, it is important that there be appreciation of the distinction between “mental health treatment,” a holistic concept, and “mental health services,” a limited, instrumental concept. Effective mental health *treatment* presupposes understanding and consensus, and thereby provides clear direction for the effective *use* of services. In the absence of a comprehensive understanding of the child from a biopsychosocial perspective, a hypothesis to explain behaviors of concern in terms of their probable function, knowledge of family and community strengths, supports and culture, and agreement among team members as to goals and strategies – services cannot be expected to result in a useful treatment process or to produce desired treatment outcomes.

Adequacy of information is important for all levels of care, even when a psychiatric or psychological evaluation and an ISPT team meeting are not prerequisites for authorization. For example, a child in acute crisis may receive an emergency room evaluation by a physician without the immediate creation or convening of an interagency team, and then be admitted directly to an inpatient psychiatric facility. A child in need of outpatient treatment may be assessed by a mid-level mental health professional rather than a psychiatrist or psychologist, at least initially, and no interagency team may exist. In both these situations and others, broad-based information about child and family is needed, so that both the services selected and the overall treatment approach are appropriate.

As part of information gathering, the child and family culture deserves specific attention. Services cannot be individualized unless cultural considerations are taken into account. The beliefs, values, practices, supports and rituals of the child and family help determine what is medically necessary and must guide mental health treatment.

Being a culturally competent clinician is a challenging process, because it involves identifying group affiliation, loyalty, and other *general* cultural characteristics of the child and family, and then moving beyond such group identities to appreciate the *unique* place of each child and family. Characteristics such as race, ethnicity, religious affiliation, gender, socioeconomic status, and type of residential community (urban, suburban, or rural) all enter into an understanding of culture. However, once these elements have been established, it is essential that the inquiry go further, so that the reality of each specific child

and family is not obscured by group characteristics that may not apply. It must be recognized that, within larger cultural units, each child and family have their own unique culture.

The process of individualizing the cultural identity of the child and family therefore requires movement beyond ethnic stereotypes (Montalvo & Gutierrez, 1988). Genuine cultural competence depends on understanding group identities and then obtaining more specific information about each child and family, so that entrapment in misleading, even damaging, generalizations is avoided.

Participation:

As an extension of the child and family, a team process becomes more meaningful when community resource persons participate. These individuals should be identified by the child and family, and invited to join the team. Unfortunately, this community-based aspect of team building often does not occur, and it cannot be assumed that it will occur on its own, without the support and assistance of mental health professionals. Once engaged, for example, a child and family advocate can educate the family and support a clear focus on the best interests of the child and family. Neighbors and community resource persons bring their unique perspectives and contributions. The integrity of the team process is strengthened when a range of community resource persons sit at the table and participate as part of the team.

While a formal ISPT is required only for certain mental health services, Pennsylvania's CASSP Principles, including the need for services to be "family-focused," are applicable to all mental health treatment. Services cannot be family-focused if the family does not participate as partners in the child's treatment process. Children enter the service system in many ways. Some are brought in directly by their parents or guardians, while others enter through other circumstances and third parties. Regardless of the route of entry, the child's family needs to be involved and, when necessary, assisted in becoming involved. In some cases, all that is needed is a welcoming approach by professionals that incorporates a sense of partnership and a readiness for collaboration. In other instances, intensive outreach and recruitment may be needed. Regardless of the child's degree of need and the service(s) being considered, it is appropriate to ask the family for information and for guidance in how to proceed. Collaboration develops through action not rhetoric, and cannot be mandated. When family members participate actively, are encouraged to participate actively, and feel valued, constructive dialogue and collaboration are likely to occur.

Participation also needs to include the child, and to focus on the child's specific strengths and needs, consistent with the CASSP Principle requiring services to be "child-centered." The nature of the child's participation will vary according to such factors as chronological age, developmental level, level of current psychiatric impairment, past treatment experiences, and attitude toward professionals, but the child's participation should always be promoted. Parents and guardians should be asked for their suggestions regarding how best to engage the child. In addition, professionals need to be guided by two principles that, despite their apparent simplicity, constitute the foundation for working with children:

- the need for unconditional respect, and
- the need to allow the child to "save face" in response to an embarrassing or uncomfortable problem or situation, as a precursor to potentially meaningful change (Hodas, 1999).

Finally, a team with integrity includes the participation of other involved child-serving systems. It is important that participants from other systems be familiar with and committed to the child and family, since the presence at team meetings of individuals with whom the family is unfamiliar can be intimidating. Once assembled, all team members need to move beyond a sole allegiance to the specific system or agency they represent, in order to address collaboratively the actual needs of the child and family being served. To achieve this, each team member needs to respect and value the contributions of the other team members.

Consensus:

Assuming that the appropriate individuals are participating and "sitting at the table"—whether or not a formal ISPT meeting is required—it is important that consensus be achieved regarding goals and service(s) to best meet the child's needs. As previously discussed, service selection goes beyond establishing that an objective medical necessity standard has been met, since a child may be eligible, based on level of impairment alone, for many different services. The task of the team is to consider the likely effectiveness of various service possibilities for the child. The process of reaching consensus is difficult and rarely, if ever, automatic. However, when all participants feel respected and are able to become "partial" to the child's needs (see Hodas, 2001, *The Real Impartial Review*), consensus can be achieved. It is important that the focus remain clinical and that there *not* be premature determination of services to the exclusion of holistic discussion of the child and family and the identification of strengths and goals. Success and "winning" must be

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equated with the achievement of consensus rather than the ascendancy of one party over another. Appreciation that treatment is a work-in-progress, capable of ongoing modification, can assist team members in achieving consensus. A predisposition toward flexibility and creativity is also very helpful, as are prior successful team experiences. Beyond good intentions, there is need for a clear protocol to guide meetings in a respectful and efficient manner, so that participants can experience a therapeutically based process leading to meaningful outcomes (Hodas, 2001, especially “Making Interagency Team Meetings Effective”). When genuine consensus is achieved, there is agreement regarding the immediate

service decision and a commitment to sustain the team and the entire helping process over time.

In summary, these three prerequisites—broadly based information, the active and respectful participation of appropriate individuals, and the attainment of consensus regarding goals and services for the child—all help ensure that treatment will be consistent with CASSP Principles. In the next section, we consider 10 specific factors *beyond the child’s specific severity of impairment* that may influence service selection.

FACTORS THAT MAY INFLUENCE SERVICE SELECTION

Ten factors are discussed below that relate to, but also extend beyond, issues of medical necessity, particularly when the latter is narrowly constructed to reflect solely or primarily the child's level of psychiatric impairment. In Pennsylvania's public sector, the primary methodology for determining medical necessity for children's mental health services involves application of a document known as Appendix T, which was developed by the Department of Public Welfare (DPW) and is part of the Request for Proposals for HealthChoices Managed Behavioral Health Care.

Appendix T identifies medical necessity criteria for a range of children's services, including outpatient, inpatient, partial hospital, RTF, and BHRS. Within the BHRS category, Appendix T identifies four severity levels, based on the degree of a child's psychiatric impairment. Level 1 entails the least amount of impairment (and least intensive service response) and Level 4 the most. It is expected that, as the child's severity level increases, the intensity of services will usually increase. Children in Levels 3 and 4 present with high degrees of safety risk and are also typically at risk of out-of-home placement, as a consequence of their SED. Appendix T has been helpful in determining medical necessity for services for children. Limitations involving its use have included a lack of clearly differentiated clinical profiles for each level of care, a lack of clinical specificity for service intensity within each BHRS level, and its focus on specific levels of care and services without regard to other professional services already in use or being considered, and the role of natural supports.

A promising tool for assessing a child's degree of need for mental health services, developed by the American Association of Community Psychiatrists in association with the American Academy of Child and Adolescent Psychiatry, is the Child and Adolescent Level of Care Utilization System (CALOCUS) (Fallon et al, 2002). This instrument assesses the child across six dimensions (risk of harm, functional status, co-morbidity, recovery environment, resiliency and treatment history, and treatment acceptance and engagement). Based on the results of this broad-based assessment, the CALOCUS then assigns the child to one of six levels of care, from least intense (Level 1) to most intense (Level 6). Within each level of care, there are many potential, acceptable service responses and combinations. As such, the CALOCUS encourages consideration of the broad array of services, not just one service type, and it identifies the total service need of the child, rather than the intensity of individual services

in isolation. It should be appreciated that the CALOCUS is a tool to be used in association with a system of care's medical necessity guidelines (such as Appendix T), and does not itself create or constitute medical necessity criteria. Although not presently in use in Pennsylvania to help determine level of care, the CALOCUS has been used in other states and could be used to good advantage here in association with Appendix T. In addition to the CALOCUS, there are other tools, including the Child and Adolescent Functional Assessment Scale (CAFAS), which can also be used to help determine a child's degree of need.

Regardless of the specific process and instruments used to assist with the determination of a child's level of care and specific mental health services, the 10 factors discussed below merit careful consideration. A discussion of each follows.

The Least Restrictive Option

Based on both CASSP Principles and clinical common sense, one goal of service selection involves providing the least restrictive service to a child. Restrictiveness refers to the degree of *confinement* and *inhibition of movement* inherent in a particular service. The most restrictive services are those that involve placement of the child in a facility supervised on a 24-hour basis, with inpatient psychiatric hospitalization more restrictive than a mental health RTF. In the past, a restrictive setting was often accessed by default, because viable services of sufficient intensity did not exist to provide the necessary structure, support, and supervision for a severely impaired child in the community. The development of off-site services (e.g., services not confined to a clinic setting) has allowed necessary treatment intensity to be achieved for some children in the least restrictive option of the home and community.

The Least Intrusive Option

Another service goal, also based on CASSP Principles and clinical common sense, involves providing the least intrusive service to a child. Intrusiveness refers to the *frequency* (number of days/week) and *intensity* (number of hours each day or week) of service provision. With home-based services, the frequency and intensity of services affect the degree of professional entry into the child's and family's personal space (the home environment), so *space* can be regarded as another dimension of service intrusiveness. For children with severe psychiatric impairment, the selection of a less restrictive setting often

entails greater-than-usual intensity. For example, diversion of a child from inpatient hospitalization may entail a high intensity of BHRS (although use of an acute partial hospital program may be another option). Thus, in determining the most suitable service for the child, a choice may at times need to be made between a high level of restrictiveness and a high level of intrusiveness, on a temporary basis, for a community-based alternative.

Expected Service Duration

The expected duration of a service is another relevant variable. Such considerations may be relevant for a child who is seen as potentially needing either RTF or inpatient psychiatric hospitalization. In accordance with the least restrictive principle, the RTF would be recommended over inpatient, since the former is less restrictive than the latter. However, if expected service duration is considered, the recommendation could be reversed. A child admitted to an RTF will likely be removed from the community for an extended period of time, while an inpatient admission will likely last several weeks or less. In like manner, a child newly diagnosed with bipolar disorder might be preferentially admitted to a short-term inpatient psychiatric hospital for psychotropic medication stabilization, even though the child's history of behaviors and poor community adaptation might also be consistent with placement within the RTF level of care.

Longitudinal Service History

For some children, the previous service history creates a de facto rationale to use certain services and/or avoid others. For example, consider an 8-year-old child with three prior psychiatric hospitalizations who is again in crisis. Sufficient impairment is present to justify another inpatient admission. However, this time the team wants to try to break the cycle and keep the child in the community. This is especially important because in the past the child has enjoyed the hospital experience a great deal, and the child's parents lost confidence in themselves. In response to the child's specific longitudinal service history, the team may choose to develop an intensive community-based plan for hospital diversion, with careful attention to issues of safety, thereby enabling the child to remain at home while also empowering the child's parents with necessary assistance and support.

Similar considerations emerge for a child with previous RTF placements who adjusted poorly to each community re-entry. Before recommending RTF readmission again, the team might carefully consider possible reasons for prior community breakdown and explore different potential community-based approaches for the child.

Specific Family Need or Preference

While family participation is central to the entire treatment process, in some cases a specific family need or preference pre-emptively influences service selection. For example, a family concerned about more than a single child may choose FBMHS rather than BHRS, because FBMHS broadly addresses the needs of each member and the family as a whole, while regulations related to BHRS typically require focus on a single identified child. When a child's parents identify concerns about ongoing parental conflict, they might also opt for FBMHS, given its family focus. Similar considerations might apply for the family in which one or more parents has a substance abuse or mental health problem, since this service actively supports parents, and for the multi-generational family, given the systemic orientation of FBMHS.

Other specific circumstances in which family preference might be especially important include the following: the family with a previous positive or negative experience with a specific service; the family whose neighbor's child received a particularly helpful service; and the family with prior experience with a specific agency or practitioner.

Congruence Between Site of Service and Site of Primary Need

The choice of service should be consistent with the child's primary identified need. For example, for the child in constant conflict with parents and younger siblings, use of an afterschool program would remove the child from the home without helping the child make necessary changes in the most problematic context—the home. On a short-term basis, the problem might appear to be solved, but experience at home on the weekends and over time might demonstrate otherwise. While the child might benefit in other ways from the afterschool program, here the primary need would remain unaddressed.

In contrast, for the child who is withdrawn and isolated from peers yet doing well at home, an afterschool program might represent a good match. While BHRS might be used to help the child develop community attachments and improve peer relationships, the child in question might benefit greatly from the structure and support of an on-site afterschool program.

Issues of congruence and matching become important when a child is being considered for admission to a mental health RTF. Such placement is most appropriate when the child is unable to function in multiple community-based settings (not impairment in just one setting) and when

comprehensive community-based treatment (including use of psychotropic medication, when indicated) has been ineffective. When the child functions poorly primarily in the home, RTF should be requested with caution, since the likelihood of effectively addressing home-based issues increases with the child at home, not in institutional care. In addition, when the child is out of the home and some distance away, it is often difficult for parents to attend RTF meetings with sufficient frequency to address critical relationship-based issues. For these reasons, alternative such as Family-Based Mental Health Services (FBMHS) or host home, if the child requires out-of-home placement, should be carefully considered.

Specific Characteristics of Community Services and Local Providers

In some communities, there is general consensus that a particular program is outstanding. Under such circumstances, the team might opt for that program for a suitable child who is also eligible for other services. Thus, a highly regarded afterschool program specializing in the use of music and art might constitute a good match for a child with artistic ability, rather than use of generic BHRS. In contrast, if a program is known to have had significant staff turnover or otherwise be in transition, then the team might select a different service option.

Unfortunately, some communities, especially rural areas, do not have a full range of service options. Under ideal circumstances—consistent with the true meaning of “wraparound” and individualized treatment—a service is created and developed when needed. In the real world, unfortunately, such timely service development does not always occur. Thus, in the short-term, the child may need to access an appropriate but less-than-perfectly matched service. Under such circumstances, the long-term goal should be to expand and further individualize the local service array.

Nature of Natural Supports

As previously discussed, appropriate service selection should not be based solely on the severity of the child's impairment in isolation. Family strengths and community resources, referred to as natural supports, always need to be recognized and considered. Certain cultures, such as African American, Latino, Native American and Asian cultures, typically draw extensively from a range of natural supports. These include the extended family, the minister or priest, and in some cases natural healers. The need to become aware of the culturally-based supports of different groups constitutes another reason for clinicians to strive to attain cultural competence. At the same time, it is important

that professionals not over-estimate the capacity of natural supports or healers and for that reason withhold professional services. What is needed is a balance of professional services and natural supports, since both serve important functions.

Unfortunately, prescriber evaluations and treatment plans are often silent on the issue of natural supports. There are many possible explanations for this. One factor may be lack of visibility of, and knowledge about, natural supports. It takes work to learn about current resources, and about untapped, potential ones. It may also be that the acuteness of many clinical situations leads participants to think about professional services and overlook natural supports. Sometimes practitioners overestimate the promise of professional services, despite the reality that it is natural supports, not professional services, that ultimately sustain improvement and stability.

Finally, it may be that an undesired (and hopefully, diminishing) adversarial process leads prescribers and teams to downplay natural resources, in an attempt to maximize authorization of professional services. Whatever the reasons, it is important to recognize that natural supports are an indispensable part of a comprehensive response to a child and family, even during the acute phase of treatment.

Legal Issues

At times, service selection may be influenced by child or family legal issues. For example, a child who is arrested may be placed in secure detention by the courts. Whether or not this is the best disposition for the child from a clinical perspective becomes less relevant, at least during this period of time. However, the placement of a child in any facility or setting should not interrupt needed treatment. The child in secure detention should have access to therapy and to medication, if needed. Likewise, the family should be given the opportunity to participate, and all involved systems should collaborate actively.

Presently, when a child is placed in detention, treatment discontinuity frequently occurs, although there are exceptions. Despite funding challenges for this setting, future agendas should include greater attention to children in juvenile facilities. A general principle pertaining to the care of children is that legal mandates do not obviate the need to address a child's mental health needs. At the same time, it should also be recognized that a legal mandate for mental health placement does not in itself establish medical necessity for that placement, since medical necessity is determined clinically.

Legal issues enter in some cases when the child's welfare is involved. For example, for reasons of child protection, some children are removed from the home. Even if a child and family prefer that the child remain at home, a child protection mandate needs to be followed. When the child is out of the home, it is important that family needs and family participation not be overlooked. Services and supports should be offered to the child's family proactively when the need is identified, rather than awaiting the child's return. In addition, the family should be encouraged to participate in the child's treatment, unless legally prohibited. In many cases, such prohibitions are temporary and conditional on resolution of specific issues. In rare situations, parental rights are terminated.

Ad Hoc Responses to Need

Ad hoc responses are creative, "out-of-the box" service responses to the needs of a particular child and family. Under such a circumstance, it is more accurate to say that the service is discovered or invented, rather than accessed and selected, since it is not part of a pre-existing,

categorical set of services. In a truly individualized system of care, including one with a comprehensive service array, the most valuable service often does not yet exist and is developed ad hoc by the prescriber and team. Ad hoc service responses are consistent with the CASSP Principle of child-centeredness, and more broadly with wraparound as a process, as opposed to the unfortunate identification of wraparound with the use of a discrete set of categorical services and a funding stream.

An ad hoc response, because it is individualized and closely matches a child's specific need, is often of limited intensity. It may involve a combination of professional services and/or use of natural supports. In some instances, an ad hoc response can substitute for either a traditional service or for BHRS. In other instances, the ad hoc response decreases the intensity of, but not the need for, other professional services. In general, the development of ad hoc responses to a child's need reflects integrity and creativity within the team.

AN EXAMINATION OF SPECIFIC SERVICES

We now consider the array of mental health services for children that are available in Pennsylvania. In the discussion that follows, we consider services for school-aged children through adolescence. Each service is described and assessed in terms of clinical indications, strengths and limitations. Not addressed are mental health services for preschool children or substance abuse services.

In reviewing the discussion that follows, the reader is encouraged to keep the following generic points in mind:

- Understanding the entire array of mental health services increases the likelihood that service selection will be informed and draw from a range of possibilities, instead of relying on a narrow list of commonly used services.
- The discussion of each service involves a description of that service as it exists today, with some comments and recommendations. The reader and multiple stakeholders should consider how to further conceptualize and develop these services, beyond the ideas presented here.
- The current service system as described should be viewed as a system of care in progress. There is room, and indeed need, for additional service options and approaches.
- Many of the bulletins and regulations that govern the use of children's services are identified at the end of the paper; therefore, they are generally not referenced in the discussion of each specific service (see Appendix C).

Specific Services in Order of Level of Restrictiveness

1. Outpatient therapy

Description:

Outpatient therapy is an on-site, clinic-based service that can serve the individual child, and the child within the context of his or her family. Until the late 1980s, when Family-Based Mental Health Services (FBMHS) were developed in Pennsylvania, outpatient therapy was the only mechanism other than partial hospitalization for community-based services. Typically, outpatient therapy is conducted once a week, but the frequency is based on need and can be twice or more per week or less often. It also offers a setting in which services can be provided on an intensive basis, commonly often referred to as "intensive outpatient." The concept of intensive outpatient services, emanating from the private sector, is increasingly being employed in the public sector.

Clinical indications:

Outpatient psychotherapy is indicated for children and families when the issues of concern can be addressed through clinic-based therapy without the necessity of interventions at specific home and community sites, and when the child does not need more restrictive levels of care. The use of outpatient presupposes a resourcefulness and capacity on the part of the child and family to attend meetings regularly and to generalize the gains from the

therapy to relevant life settings. Although frequency of outpatient therapy can vary according to need, it is often less intense than home-based services, so this service is appropriate for children and families already possessing some independent problem solving skills.

Strengths:

Outpatient therapy is the least restrictive community-based treatment service within the array of services. The child or family goes to a service site for therapy. While variable, the frequency typically is not extensive and each session usually lasts between 50 and 90 minutes. Because the service is on-site, the client takes the initiative of remembering the appointment time and getting there, which reinforces self-sufficiency. In addition, because the site of service is the clinic, the boundary between the therapy process and the family home remains unaffected. The experience of therapy becomes a discrete process occurring one or more times per week in the community, away from the home. The client then returns home, which under usual circumstances is off-limits to the therapist, and follows his or her usual routines, incorporating when possible gains from the sessions.

The child in outpatient therapy typically has access to a psychiatrist at the same or an associated facility.

Medication monitoring, when indicated, is built into the service delivery.

Limitations and quality improvement issues:

An unintended consequence of the availability of BHRS has been a tendency to disregard the therapeutic benefit of outpatient therapy. There should always be serious consideration of the indications for outpatient therapy, given our commitment to least restrictive and least intrusive service selection. In many cases, the outpatient level of care, which enables the child and family to receive necessary treatment while maintaining a more typical community lifestyle, will be appropriate.

There are circumstances where outpatient therapy, even intensive outpatient, may not be sufficient. This includes situations in which the child's level of impairment raises ongoing, unresolved safety concerns. Other situations include a clear need to intervene regularly in the child's natural contexts of functioning (the family and community), limited self-sufficiency, or when sporadic attendance or lack of engagement with the therapist prevents a consistent process from occurring.

In addition to the need for a change in service culture so that the use of outpatient is viewed positively when indicated, additional issues include strengthening the infrastructure for this service and offering more support to outpatient practitioners, who often work with a high volume of clients in relative isolation. In addition, there is need to ensure sufficient psychiatric time.

Overall assessment:

Outpatient therapy remains a cornerstone of a comprehensive system of care. It should not be assumed

that home-based services are intrinsically more appropriate for all children and families. When the child and family can benefit from traditional outpatient therapy, the service should be used, because the boundary between home and therapy is maintained. When this boundary is crossed (as is necessary for some children with SED), a new reality develops for the family regarding the role of therapy in daily living, bringing with it a certain service dependency. A challenge for the system of care is to increase the flexibility and scope of clinic-based outpatient services, so that there no longer are incentives to provide off-site services when clinic-based services might suffice. The viability of outpatient therapy as a core service could be further enhanced under the following circumstances:

- support for selective off-site networking functions for the outpatient therapist, as needed;
- transportation more readily available to families who might otherwise be unable to use this level of care;
- use of more community-based sites (including school-based sites) as settings for outpatient treatment;
- more frequent consideration of intensive outpatient as a bridge between regular outpatient and partial, when service options are being considered;
- the investment of additional funds to build up the infrastructure of outpatient services in the community;
- attention to the supervisory and support needs of outpatient therapists;
- a more favorable reimbursement rate for psychiatrists, so there would be less scarcity and greater capacity to use psychiatrists to enhance overall clinical quality.

2. School-based mental health services

Description:

"School-based mental health services" is a generic term referring to the provision of mental health services within the context of one or more schools. Specific services may vary. For example, a mental health professional can be available to meet with and inform teachers and/or counselors about mental health issues and provide informal consultation on specific students. The mental health professional can also sit in on specific classes for designated periods of time and then offer feedback to the teacher about classroom dynamics, specific students, and the management of problematic behaviors.

School-based mental health services can involve the availability of a psychologist or psychiatrist to provide specific evaluation of students identified by teacher, counselor, principal, and/or parent. (Note: Unless it is an emergency situation, such evaluations are not conducted without parental consent). School-based mental health services can also involve ongoing programs that offer services to specific children; for example, regular outpatient therapy delivered at the school.

In some communities, other systems also offer services within the school setting. For example, juvenile probation

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by Gordon R. Hodas, M.D.

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officers and child welfare case managers may have offices in some schools, and selected services for adults may also be school-based.

For purposes of this discussion, school-based services refer to the range of possibilities identified above and not the use of BHRS in the school setting. Either way, the need for coordinated and collaborative efforts between the two systems is the same.

Clinical indications:

Given the broad range of services that may be school-based, clinical indications will vary. School-based psychotherapy may be indicated for any child for whom outpatient therapy is indicated, with the advantage that the child can receive the services during the school day, on school grounds. School-based psychiatric and psychological evaluations are indicated for any child about whom there are significant emotional and behavioral concerns, provided that the child's parents consent to the evaluation in non-emergency situations.

Strengths:

School-based mental health services make good sense, given that students are already on school grounds and readily available. If a school culture accepts on-grounds mental health services, this may reduce the stigma often associated with such services. When there is an ongoing mental health presence in a school setting and when many children receive services, issues of shame and reluctance to participate are often reduced. An effective school-based mental health program ensures that there is a mechanism for communication between the therapist and the classroom teacher. Such collaboration informs and empowers both, ultimately benefiting the child. In general, the concept of the school as a repository of human services for children and others is a progressive idea. By incorporating services for parents and other adults, recreational services, and family centers, the school can become part of a community development strategy, with human services more accessible and public facilities seen as more actively serving community members.

Limitations and quality improvement issues:

Implementation of school-based mental health services must overcome the long-standing tradition of mental health services (with the exception of relatively recent home-based services) being housed in mental health clinics, and schools being used only for education. Schools and mental health agencies have separate administrative structures and, to a degree, separate cultures. Mental health providers may

be reluctant to move their base of operations off-site to the schools, due to uncertainty about the continued autonomy of these services and the readiness of school officials to be welcoming. Issues of funding and office space may further complicate matters. From the school's perspective, if there have been problems in the past with referrals and treatment, there may be reluctance to invite in mental health. Yet the benefits of this potential collaboration should not be overlooked.

It is important that teachers and mental health personnel maintain realistic expectations. Teachers need to appreciate that the presence of school-based mental health personnel does not guarantee that there will no longer be disruptive students. Mental health staff must appreciate that, while they may be working with one or two children in a particular class, the teacher is responsible for the entire class. These kinds of issues typically work themselves out when there are ongoing mechanisms for review and debriefing.

When mental health services are provided for a student in the school setting, it is especially important that there be clarity of goals and buy-in by both mental health and education, with coordination of all interventions. Clarity regarding goals and approaches to be used should be achieved before services begin, with mechanisms for ongoing review identified. Planning for school-based services can avoid misunderstandings and antagonism and help the child achieve identified mental health goals within the school setting.

At a level higher than the individual teacher and mental health professional, an effective program involving use of school-based mental health services is supported when designated school and mental health administrators meet regularly and are prepared to address problems and plan proactively. In addition, in order to create legitimacy and a broadly based sense of mission, school-based mental health initiatives should be discussed with parents and the community at the planning stage, prior to implementation. These programs, desirable though they otherwise might be, may be viewed skeptically if the input of families and the community is overlooked.

Similarly, school-based mental health services for specific children need to incorporate family participation in treatment. With the child readily available on-grounds and the primary hours of school-based services being the daytime, it may seem unrealistic or inconvenient to involve the family. The goal is not to make family participation mandatory, but to work with the family to make participation desired and feasible. A service plan that includes school-based mental health services should clearly

identify the mechanisms and sites of family participation in the child's treatment.

Overall assessment:

School-based mental health services are a positive development in the present and a hopeful trend for the

future. There are many advantages, and the potential pitfalls can be avoided through communication and perseverance by all parties. Beyond school-based mental health per se, the potential use of the school as a site for broad-based services and community gatherings, and as a catalyst for community development, has much to recommend it.

3. Behavioral Health Rehabilitation Services (BHRS) for Children and Adolescents:

Description:

The term Behavioral Health Rehabilitation Services (BHRS) for children and adolescents refers to a range of medically necessary, off-site (e.g., out-of-clinic), community-based services for children with SED, up to age 21. BHRS has been referred to by other designations as well, such as "wraparound services," "home and community services," "enhanced mental health services," "Provider 50 services," "behavioral health services," and "EPSDT services." In this paper, the designation BHRS is used.

The availability of BHRS in Pennsylvania emanates in large measure from the Commonwealth's conscientious interpretation and implementation of OBRA 89, federal legislation from 1989. Although frequently equated with three specific off-site services that have been listed on the Pennsylvania MA fee schedule (see below), BHRS as a service designation can encompass a broad range of individualized services for the child, developed in response to the individualized needs of one or more specific children and their families. In fact, initially the Pennsylvania Department of Public Welfare (DPW) encouraged providers to submit their own service descriptions for services deemed medically necessary for one or more children with SED. The result was a broad range of submissions. While there were problems with redundancy, this approach nevertheless recognized and acknowledged the potential variability and flexibility of a service array subsumed under the designation of what we now refer to as BHRS.

In 1994, DPW issued a Bulletin (see Appendix C) identifying three specific BHRS services: Mobile Therapy (MT) and Behavioral Specialist Consultant (BSC), staffed by mental health professionals with at least a Master's degree and specified experience, and Therapeutic Staff Support (TSS), now staffed by a mental health paraprofessional with a Bachelor's degree or at least 60 college credits and specified experience and training. (The Summer Therapeutic Activities Program, or STAP, another

specific BHRS, was developed later and is discussed elsewhere). By definition, these services are offered in the home and community, including the child's school setting, when medically necessary, to support the continued community tenure of the child with SED, and are not offered in a clinic setting. A summary of each of the three BHRS services listed on the MA fee schedule follows:

1) Mobile Therapist

A Mobile Therapist (MT) is a therapist, similar to an outpatient therapist in many respects, who meets with the child in the home, school, and other community sites as appropriate and as identified in the child's treatment plan. When BHRS is used, the MT typically serves as the "primary clinician"—the individual with primary clinical leadership responsibilities—although this role may also be assumed by an outpatient or community therapist, when MT is not used. The MT can help the child with individual goals (such as controlling temper or dealing with depression), family goals (such as getting along better with parents or siblings), and community goals (such as developing and maintaining peer relationships and community attachments). The MT can work with the child individually, the family as a whole, and various family subsystems, as long as the interventions are related to the needs of the child in question. The MT can also work with community resource persons as part of the therapy for the child. Such individuals may be seen with the child, parents, and/or the entire family. The MT, like the traditional outpatient therapist, can develop a treatment plan for the child, and can include behavioral approaches as part of the interventions used. The use of Mobile Therapy does not necessitate concurrent use of BSC (see below), nor is the MT restricted from using behavioral approaches or developing a treatment plan.

Regardless of the specific roles of the MT identified in the treatment plan, the MT is expected to link all intervention efforts back to the child's parents or guardians. There is thus need to clarify the nature and limitations of confidentiality with the child, and also to ensure that the

child and family understand that the goal of treatment involves both helping the child individually and also supporting parental leadership. Such explanations are best introduced as part of the service orientation, and can then be reinforced as treatment proceeds.

2) Behavioral Specialist Consultant

According to the 1994 Bulletin, the Behavior Specialist Consultant (BSC) is a consultant resource for a child in need of specialized behavioral interventions. The BSC is to be used under exceptional circumstances. The role of a BSC, when involved, is different than that of a therapist. By focusing on the specific behaviors of the child, the BSC—unlike the primary clinician—is not responsible for addressing the “whole picture” of the child, which includes more than just a child's behaviors.

The BSC, when involved, is expected to gather information related to the child's problematic behaviors, develop a plan of behavioral intervention, and assist others in implementing it. The BSC also monitors the child's response to the plan, and makes modifications based on needs and outcomes, in consultation with the child's parents, other caregivers, and the primary clinician. The BSC may need to observe a child in multiple settings and talk to those working with the child, including but not limited to the child's parents. A major goal of BSC consultation with the child's parents involves the transfer of information and skills. When TSS is also being used, the BSC obtains information from the TSS worker that can guide future interventions. The BSC is expected to work closely with the primary clinician, and is properly viewed as a consultant to this individual. While the BSC has direct contact with the child, this is to gather information, ensure that the child “buys into” the behavior plan, explain proposed techniques, and monitor progress. This kind of contact is quite different from the provision of psychotherapy, which is not a BSC function.

Under most circumstances, it is not appropriate for the BSC to be the sole mental health professional within the child's team. This is because the BSC, by design, focuses on discrete behaviors rather than the whole child, and is a consultant rather than a therapist.

3) Therapeutic Staff Support

The Therapeutic Staff Support (TSS) worker is a mental health paraprofessional, not a mental health professional. Until June 2001, a TSS worker was required to have a Bachelor's degree. Currently, an individual with an Associate's degree or 60 college credits can also serve as a TSS worker, so long as specific experience and

training requirements are also met.

TSS provides a one-to-one service to a single child and family. The TSS worker, with oversight by an involved mental health professional and with regular professional supervision, serves a “hands-on” function, working closely with the child, family, and other adults to help implement specific behavioral health interventions in the written treatment plan. The functions of a TSS worker are individualized according to the specific needs of a child at that time, with the TSS worker's tasks clearly identified within the child's treatment plan. Data and other information from the TSS worker, shared with the team, can serve as the basis for modifications of the child's treatment plan and overall treatment strategy.

TSS, provided in varying degrees of intensity as appropriate, can be used to promote a range of goals. TSS roles may include any of the following: supporting the child's adaptation in the home with the family, promoting the child's behavioral functioning in a school setting, promoting the child's community integration, and at times supporting the child in acute settings, as part of an intensive and integrated response. In general, TSS should be used only when it is clear that the efforts of mental health professionals, in combination with the family and community, cannot meet the child's mental health needs satisfactorily. Efforts should be made to follow the least restrictive/least intrusive service principle, in terms of both intensity of service and duration of use.

The need to link intervention efforts to the parents and other caregivers is especially important with the use of TSS. This occurs both through the sharing of information and through direct interventions in the home, consistent with the child's treatment plan. When an identified TSS role involves helping the child integrate more effectively in the community (for example, by participating effectively on a community sports team), outcomes from these efforts should consistently be reviewed with the child's parents. One way for the TSS worker to maintain a family-centered approach is by beginning and ending each contact with the child by discussing interventions and talking, at least briefly, with the child's parent(s). Such contact benefits both the parent and TSS worker, as information is exchanged and a spirit of collaboration reinforced.

Clinical indications:

BHRS, as a level of care, is indicated when it is clear that treatment of the child's SED requires the interruption of the usual boundary between home and services, because the child and family are unable or unlikely to benefit from clinic-based services and BHRS is deemed preferable to the

use of available traditional services. Clinic-based services may be insufficient due to the severity of the child’s impairment, the need to treat the child in the specific contexts in which problematic behavior occurs, and/or the inability of the child and family to attend clinic-based therapy regularly. Some children who require BHRS have received a variety of unsuccessful services in the past, and BHRS (as with FBMHS) may represent the last intervention before out-of-home placement would become necessary. Based on need, as discussed, BHRS can be used in the child’s home, community, and school.

While BHRS may be essential in certain circumstances, it should be appreciated that, once the family gets accustomed to home-based services, their experience of mental health treatment and conception of privacy are substantially altered. Therefore, while it is not necessary for a child to “fail first” with outpatient therapy when medical necessity for BHRS is present, care should be taken not to use BHRS if it appears that the child might respond to outpatient or other traditional services.

When TSS is used as part of BHRS, the child and family experience of treatment is further altered, and potential service intrusiveness becomes a concern. Therefore, the decision to use TSS should be made deliberately and in some cases, a more gradual approach may be preferable—deferring the TSS decision in favor of initial services involving only a mental health professional. Regardless of the specific BHRS used, the goal is to promote a blending of natural supports with use of professional services, so that child and family independence and self-sufficiency are promoted.

Strengths:

The capacity of Pennsylvania’s children’s service system to provide services off-site in the child’s home and community—the child’s and family’s natural settings—represents a major shift towards flexibility. That such community-based interventions are recognized and reimbursable reflects progressive efforts on the part of the Commonwealth in addressing the mental health needs of children and their families.

Although often not fully used as such, BHRS also represents a broad window of opportunity for providers and teams to creatively address the behavioral health needs of children in the public sector. Such initiatives need not be limited to currently developed services or services identified on a fee schedule. In fact, a broad range of potential services to benefit the child with SED and the family can be subsumed under the umbrella of “BHRS.” Such responses constitute *ad hoc* BHRS services, since

they result from an individualized response to a specific child in need rather than from a menu of pre-existing services.

Limitations and quality improvement issues:

In Pennsylvania, BHRS is often referred to as “wraparound services.” This identification of wraparound with a specific set of services and a specific funding stream is unfortunate, since wraparound, as developed by John VanDenBerg and others (see, for example, VanDenBerg & Grealish, 1998, and Stroul, 1996), is best conceptualized as an approach to care and a “way of doing business.” True wraparound is an individualized approach to the mental health treatment of children and their families, in which each service response is based on the unique strengths and needs of the child and family. Goals of wraparound include addressing the child’s needs so that the child remains at home and in the community whenever possible, promoting the child’s normative development, and enhancing family self-sufficiency. Key elements of the wraparound approach to care include:

- the use of a local child and family team;
- the presence of a supportive, high-level administrative structure or teams (in Pennsylvania this may involve a team at the level of the county or joiner, or the county-managed care organization entity);
- a commitment to collaborate actively and respectfully with the family and all involved child-serving partners;
- creative treatment planning based on a comprehensive understanding of the whole child within multiple life domains;
- ongoing promotion of active parent and caregiver participation, with increasing responsibility for care assumed over time by parents or other caregivers, facilitated by provider feedback and ongoing dialogue;
- the conjoining of natural supports with professional services and the use of flexible funds, with the goal of promoting family empowerment and self-sufficiency;
- a commitment to avoid punitive responses to the child and the discontinuation of care as a punitive response to behavior.

Viewed historically, the intent behind the Commonwealth’s development of what has become known as BHRS was to increase clinical flexibility within the public sector and to provide an impetus for the children’s system to move beyond primary reliance on limited categorical services. DPW’s decision in 1994 to add MT,

BSC, and TSS to the Medical Assistance Fee Schedule was intended to make these newly identified options easy to access, not to promote over-reliance on them or a disincentive for the development of other services.

The overuse of TSS in particular has created a series of unanticipated consequences. In the absence of a full understanding of the scope and limitations of this service, TSS utilization has grown rapidly. A capacity problem has developed, along with concerns about inexperience, turnover, less-than-optimal matches with families, fragmentation, and outcomes. As we move forward, care must be taken to ensure that appropriate expectations are placed on TSS workers, that interventions occur in partnership with the family, and that TSS training includes a thorough grounding in CASSP Principles, the system of care philosophy, and a range of specific skill sets.

Other BHRS-related problems have involved the routine reliance on BSC, at times even in the absence of a primary clinician, and in other cases the routine bundling of BSC with MT, despite the fact that the 1994 OMAP bulletin identifies the BSC service as exceptional. The overuse of BSC may have had many determinants. In some circles, the mistaken idea emerged that only a BSC could write a treatment plan. A companion misconception held that only a BSC could address behavioral problems and collect data. The long-standing experience of clinicians in clinic settings prior to the availability of BHRS certainly indicates otherwise, since the development of behavioral interventions and treatment plans were all clearly within the purview of the outpatient therapist.

Another element appears to have involved the strict construction of the MT role, whereby Fee-for-Service limits billable MT time to face-to-face contacts, excluding collateral networking functions. Collateral functions include collecting information, meeting with adults in addition to parent involved with the child, and attending team meetings. It is well recognized by clinicians that collateral functions are essential to good clinical care. The current service system, by providing payment for collateral functions only by the BSC and not by the MT, may have created an unintended incentive for the bundling of both of these services, since the BSC could fulfill certain functions unsupported for the MT.

Overall assessment:

The scope of discussion allocated here to BHRS reflects its impact, both positive and negative, on the children's service system. Clearly, BHRS, as an available in-home and community option, has enabled many children

and families to experience improved levels of functioning and adaptation. Children have been supported in remaining in the community and, in many cases, with their families. In addition, nearly every stakeholder can identify situations in which BHRS made a meaningful difference. This is especially the case when treatment planning embraces the principle of least intrusiveness, and when BHRS is delivered in an active, collaborative, team-driven way, with ongoing family participation.

However, when BHRS is used less thoughtfully—with routine bundling of BSC with MT, near-automatic inclusion of TSS (often in very high intensity), and fragmentation among service providers—outcomes often are disappointing, and may reinforce family perceptions of hopelessness, disability, and service dependency. Too often, the response to treatment stalemate appears to involve the use of more services, rather than thoughtful and systematic analysis. A vicious cycle may follow, in which each failure becomes the basis for more services, rather than a catalyst for re-examination of the diagnosis, specific approaches to treatment, and even the choice of services. Ironically, the availability of BHRS has sometimes had an inhibiting effect on creativity and new approaches to service development and treatment.

The overall assessment of BHRS is thus complex, and many challenges remain. While in no way inclusive, the following represent some ways to address these challenges:

- support for *comprehensive* front-end psychiatric and psychological evaluations;
- the use of extended evaluations;
- ongoing awareness of the full array of services;
- the readiness, in non-crisis situations, to defer a decision regarding TSS until a therapeutic system under the leadership of a mental health professional develops;
- a more broadly conceived role for MT, supporting collateral, networking functions;
- more comprehensive initial orientation by providers for children and parents prior to the start of services, reinforced in an ongoing manner over time, regarding the wraparound philosophy and the appropriate goals of BHRS, including the need for active family participation, use of natural supports to complement professional services, and BHRS as a catalyst for long-term transformation and change;
- more standardized, comprehensive training and supervision for TSS workers;
- systematic tracking of outcomes over the course of treatment.

4. Partial hospitalization services (“partial”)

Description:

Although there is only one set of regulations that governs the use of partial hospitalization for children, the term partial hospitalization services (“partial”) as it applies to children with SED is confusing, because in practice “partial” may refer to at least three different services:

1. A full-day service for children who have shown significant maladaptation in their previously assigned regular education or special education setting. This service has historically been of long duration.
2. A full-day service for children who are at acute risk of psychiatric hospitalization or RTF placement, or who are returning from either of these levels of care. Such acute partial programs for hospital or residential diversion and community re-entry have been common for adults but less so for children in the public sector. These programs are often referred to as “acute partials.”
3. A program for children after regular school hours that uses groups and therapeutically guided activities to help the child learn to develop age-appropriate interpersonal skills with peers and to respect structure, limits, and adult authority. These are often referred to as “afterschool partials.”

All partials are intense services. Full-day partials may run up to six hours a day. Afterschool partials may run up to four hours a day. Pennsylvania regulations require that psychiatric time in a partial program be allocated according to the formula of two hours per week of psychiatric time for every five children enrolled in the program. Partial programs typically convene on weekdays. The child may attend the program five days per week or less, based on need and nature of authorization. Service tapering, as the child improves clinically, often involves decreasing the frequency of a child’s attendance in the partial program. Another method involves transferring the child from one program to another—for example, from acute partial to an afterschool partial.

Clinical indications:

An *acute partial* is indicated for a child who is at risk of psychiatric hospitalization, when the level of stability and family and community support is such that the child can return home each day and remain safe. The partial program can identify and address acute stressors, stabilize the child’s SED, and determine the most appropriate

aftercare. The partial can reassess the child’s psychotropic medication (or consider indications for such medication, if none is in use), address the child’s individual issues, and use group process and activities to create a safety net for the child within the program. The partial can enlist family participation, so there is extension of program benefit beyond specific program hours.

Full-day, non-acute partial for children who may be at lesser risk of psychiatric hospitalization and out-of-home placement is indicated when there have been sustained school-based efforts to understand and address the child’s maladaptation. It is recommended that this include educational testing and development of an Individualized Education Plan (IEP), assessment of the appropriateness of the current class placement, accommodations to address any limitations in attention and learning, a psychiatric evaluation, use of mental health services and psychotropic medication as indicated, and convening a team meeting with family participation. The child’s referral to partial, if still necessary despite all of the above, should be made with clear identification of those improvements necessary for the child’s return to an educational setting—either the current one or another better suited to the child’s needs.

An *afterschool partial* program is indicated for the child who needs to develop age-appropriate social skills and therapeutically supported peer relationships. This may be based on the child’s withdrawal and lack of initiative, or a need to learn to interact with peers without aggressiveness and intimidation. An afterschool partial can also benefit the child who has difficulty accepting adult limits and/or who needs structure to develop age-appropriate leisure/recreational skills. In general, an afterschool partial should not be used when the primary problem is family-related. While removal of the child from the home through use of partial in the afternoon and evenings may relieve tension over the short-term, such service selection does not match service with actual need and is unlikely to result in desired changes over time.

Strengths:

The Surgeon General’s Report (2000) identifies partial hospitalization as one of the services for children with some evidence of efficacy. The full-day *acute partial*, in serving children with acute presentations of crisis, offers a mechanism for hospital diversion. This is an important function in a system of care committed to helping children remain in their home and community. The acute partial also serves an important step-down function for children discharged from inpatient and RTF, who are at considerable risk as they reintegrate into the community.

As hospital stays have become shorter, with children leaving inpatient facilities less fully stabilized than in the past, the acute partial can promote the child's continued stabilization and help the child sustain improvements. The fact that there is a required ratio of psychiatric time within a partial program based on the number of enrolled children works to support service quality.

Full-day, *non-acute partials* can promote the child's reintegration into an appropriate school setting, by helping the child accept structure and limits and respond appropriately to adults and peers. In addition, these partials, by addressing the most prominent symptoms and behaviors of concern, may prevent the need for higher levels of care.

The strength of an *afterschool partial* program is that it offers a supportive setting where children with SED, isolated and with limited interpersonal skills, can learn developmentally appropriate social skills. Such programs also encourage the child's skill development through specific therapeutic activities, and may combine the use of groups and circle exercises with outdoor activities. The child in partial can benefit from the program structure, group activities, and clearly identified rules, when consistently and fairly enforced. The child in partial may be willing to take interpersonal risks that are less likely to be undertaken during regular school hours.

Because full day partial programs in particular operate during daytime hours when most parents are at work, obtaining active family participation can be difficult. The strongest partial programs make family participation a high priority and develop practices to accomplish this. This may involve any of the following:

- highlighting the commitment to, and expectation of, family participation with parents during the intake meeting and again at the time of the child's admission;
- efforts to schedule meetings as conveniently as possible for parents;
- emphasis on operationalizing the team concept during meetings, so that family input is obtained and valued; and
- ongoing, multiple phone contacts by program staff.

Other aspects of active treatment within a partial program involve the following:

- regular individual therapy for the child and the availability of family therapy, so that the child's mental health needs are addressed in an individualized way, not just through group programming;

- an active psychoeducational component for the child and family;
- regular review of treatment progress;
- close coordination with the school district and other involved systems;
- scheduling of meetings with sufficient notice, to increase the likelihood of participation by outside parties;
- active discharge and aftercare planning, with the involvement of the child, family, and involved professionals;
- active leadership by the child and adolescent psychiatrist;
- overall commitment to quality treatment, involving internally based quality improvement efforts, based on clinical outcomes and client satisfaction.

Limitations and quality improvement issues:

Some have argued that at a systems level, given the level of impairment of most children requiring partial hospitalization and the expectations of this service, partial hospitalization is one of the most under-funded services in the Pennsylvania array of services. Partial hospital rates, and resultant program designs, make it difficult for the partials to assume responsibility for programming the child's entire day, including after-program hours in the home and community. Nevertheless, contractors often maintain such expectations, with reluctance to support the involvement of concurrent home-based therapy when it appears that the level of family need exceeds the capacity of the partial to fully address.

In general, while there are many excellent partial programs, a limitation of some involves lack of individualization. This occurs when there is limited or no individual therapy for the child, little or no family participation and recruitment, and an over-reliance on group programming to address the unique problems of participants.

Group psychotherapy can be very effective, but there are many issues of individual children that may not be effectively addressed in group settings. Depressed and withdrawn children, and many concerned with issues of shame and stigma, may remain silent or guarded in groups. Individual psychotherapy—to identify and address key issues, broaden the base of information, and strengthen the therapeutic alliance—remains essential.

It is essential that providers of partial ensure that staff maintain ongoing contact with families, provide information about diagnosis and medication, and plan discharge and aftercare collaboratively with the family.

While the typical hours of full day partials create a barrier to easy family participation, the effectiveness of the service ultimately depends on the degree of family partnership achieved.

Overall assessment:

Acute partials offer structured community-based programming for children who are either at risk of hospitalization or are transitioning from that setting or an RTF back to the community. As such they serve as a mechanism for institutional diversion or a bridge back to a lesser level of care. Less acute full-day partials can also help a stressed child restabilize, and provide a setting for a child to regain sufficient functioning to be able to return to an educational setting. Since the work of children is to attend school, partial programs should endeavor to return the child to an educational setting as soon as possible, so that the child does not come to think that he or she is unable to attend school. If the previous setting was not suitable, then modifications should be made as needed, always with the goal of using the least restrictive educational setting for the child.

The afterschool partial is valuable as a vehicle for the promotion of age-appropriate social skills and the child's capacity for peer relationships. However, this service should be chosen based on specific need, rather than as a

means of removing a problematic child from the home setting during afterschool hours. In addition, since the ultimate goal for each child is integration in the community, afterschool partials should view their role as providing a means to a larger end—that of community integration.

The following represent specific ways that partial programs could be strengthened and more effectively used:

- ensuring that partials are funded consistent with the expected scope of their service;
- increasing family participation in partials, and the regular provision of information to families;
- ensuring that partials treat the child in an individualized way, and that the child in partial routinely receives individual psychotherapy;
- expanding capacity for acute partials for children, and the flexible use of this level of care;
- addressing the educational needs of children in full-day partials and making systematic efforts to return them to appropriate educational settings as soon as possible;
- maintaining realistic expectations about what partials can and cannot accomplish, so that the full needs of children and their families can be met through adjunctive use of natural supports and additional services, when indicated.

5. Family-Based Mental Health Services (FBMHS)

Description:

Family-Based Mental Health Services (FBMHS) was Pennsylvania's original home and community service program prior to BHRS. First implemented in 1986-1987 in several counties and then expanded statewide, FBMHS became an in-plan HealthChoices service as of February 1, 1997. These services are comprehensive, voluntary, off-site, community-based services for children up to age 21 and their families, developed in response to the mental health needs of one or more children within the family. FBMHS constitutes an *alternative* to a variety of mental health services, including outpatient, BHRS, RTF and inpatient treatment. Family-based services are especially relevant for children at risk of, or returning from, out-of-home placement.

Family-based services constitute a comprehensive service package. A team that involves a Master's level and a Bachelor's level professional works intensively with a small number of families, with regular supervision by the FBMHS program director or designee. Caseloads typically

do not exceed eight families. Treatment interventions are based on CASSP and family systems principles, with use of a broad range of specific techniques. FBMHS involves flexible use of services, with interventions in the child's home, school, and community as needed. The specific frequency and schedule is developed collaboratively with the family, with changes over time based on progress and need. There is 24-hour-a-day team availability as needed, including crisis intervention and emergency coverage.

Clinical indications:

As off-site, community-based services, FBMHS may be indicated when a child's SED is too severe to be addressed through outpatient treatment and requires assessment and intervention in the settings of challenge, and when the child is at risk of hospitalization, out-of-home placement, or severe deterioration. Family-based services are also indicated as step-down services for children returning to the family, following out-of-home placement. They are also indicated when a family has multi-system involvements and the child has had multiple past

placements and failed treatment efforts.

Beyond the above generic considerations, there are specific clinical circumstances in which FBMHS may be especially indicated for a child with SED. These include the following:

- more than one child at-risk for *out-of-home placement* or in need of behavioral health support;
- one or more children *returning* from out-of-home placement;
- a parent with an *individual challenge* such as mental illness or substance abuse;
- *parent request* for an intensive family approach, to unify parenting efforts;
- *conflict between separated or divorced parents*, with need to address loyalty issues, promote a more unified approach, or involve the non-custodial parent;
- presence of a *three-generational conflict*, with need to address loyalty issues and resolve the conflict;
- need for FBMHS to coordinate treatment, limit the number of additional staff, and *provide a cohesive team-based process*, for the child already involved in many different systems.

Strengths:

FBMHS is important within the array of services for children. The guiding assumptions are consistent with CASSP Principles—to support the competence and goals of families as partners, to help the child remain at home whenever possible, and to identify and create linkages with natural supports. FBMHS is implemented with a sound understanding of systems and with appreciation of the ongoing development and resiliency of children. Each FBMHS budget includes provision for 5-10 percent of funds to be used for family support, allowing for flexible responses. In addition to program-specific supervision, there are regular, mandatory regional training and technical assistance sessions for FBMHS workers that take place monthly. The fact that FBMHS uses a two-person team that works together in an ongoing manner and shares the same supervision enables it to be a highly cohesive service.

Another important strength of FBMHS involves its comprehensive training, supervision and consultation components. Training includes didactic presentations and

clinical skills development. The theory is described and applied through role-playing, use of video tapes, and case discussion. FBMHS also offers ongoing training sessions for supervisors. Overall, each FBMHS supervisor and clinician receives two days of training per month for a total of 17 days per year, and this is provided over a three-year cycle at regional training sites. In addition, new clinicians and supervisors attend two days of start-up training (Lindblad, Dore, & Stern, 2004).

Limitations and quality improvement issues:

Historically, FBMHS has had a limited capacity because prior to HealthChoices, it was county-funded rather than funded through Fee-for-Service. In those counties with HealthChoices, this limitation has now been eliminated, since FBMHS is an in-plan service. This creates the possibility of expansion of this important service.

FBMHS has the advantage of a systems perspective in addition to its focus on the child. However, there has been concern that family-based clinicians sometimes have focused on systems and family issues with insufficient attention to the specific problems of the identified child. While this may at times be the case, this limitation is not intrinsic to the service and can be addressed through effective supervision.

Overall assessment:

Family-based services are strengths-based community services that seek to support not only the identified child at-risk, but also other children within the family and the family's overall integrity and caretaking capacity. As such, FBMHS provides preventive as well as treatment functions. As with BHRS, FBMHS can include a range of specific behavioral interventions, and offers the family a supportive psychotherapeutic experience, empowering parents as leaders while expanding the problem-solving and communication skills of the entire family. FBMHS coordinates with other human service systems and the community. It is a fundamentally sound service that could be used more often than currently occurs. For FBMHS to remain a viable service option in the public sector system of care for children, there will need to be increased awareness of its benefits by interagency teams, prescribers, managed care, and others working with children and families.

6. Community residential rehabilitation services (CRRs)

Description:

Community residential rehabilitation services (CRR) are transitional residential programs in community settings for persons with chronic psychiatric disability. A CRR is a voluntary mental health service that provides housing, personal assistance, and psychosocial rehabilitation in a non-medical setting. CRRs are available to children under age 18 who are not emancipated minors. For ages 18-21, an adult CRR is applicable.

There are two levels of CRR care for children, distinguished by the level of functioning of the children served and the intensity of rehabilitation and training services offered by the staff. For children receiving CRR services, the expectation is for oversight of the child's functioning in all relevant life domains, including in the school/vocational setting and in the community, as well as in the CRR facility itself. Since a CRR placement is mental health based rather than a permanency disposition, there is need to determine the child's long-term needs and plan longitudinally. This includes the provider's working with the child's biological family, when the desired outcome involves the child's return to the family home and when there is a family available. It includes working with county Children and Youth staff, when the child is involved with that system. Longitudinal planning in some instances may involve helping an adolescent prepare for independent living.

The *less intensive* level of CRR for children involves a group home, which is a single dwelling or apartment in the community that serves 4-8 children. The group home is staffed by a provider. Each child receives mental health services as medically necessary.

The *more intensive* level of CRR for children involves a host home setting, a private residence of a family other than the child's parents that is contracted to provide a structured living arrangement for 1-3 children. There are many specific arrangements for host homes, all of which constitute home-like settings, based on the type of child primarily identified for service. Some host home arrangements serve just one child in the family, while others can effectively work with more than a single child. Based on contractual arrangements with the funding source, some host homes provide only shelter and food plus the professional host parents, who receive supervision from a mental health professional. A program psychiatrist is usually involved. Other host homes incorporate additional mental health services as part of the program. Therefore, it is important for the team to determine the specific

characteristics and responsibilities of each host home program to which a child is being referred.

By design, all host home programs require that at least one host home parent receive intensive training, before and after receiving the child. Given the degree of need of children who require this service, specialized training for the host home parent is a critical program component. Following training and the placement of a child, the host home parent is then regarded as part of the professional mental health team and receives ongoing supervision from a designated program representative. Host home parents are expected to be flexible and individualized in their management of the child, and are reimbursed at a higher rate than foster parents (who are part of the child welfare rather than the mental health system).

Clinical indications:

A CRR is indicated for children with SED whose needs cannot be managed in their own families, but who are capable of functioning in a community-based level of care with the provision of appropriate structure and supports. A child placed in a CRR may be in the custody of either his or her parents or Children and Youth. In the latter case, it is important to appreciate that the child's entry into a CRR is based on the severity of mental health needs, not his or her dependent status. In general, the dependent child without significant mental health challenges is placed in some level of foster care within the Children and Youth system, rather than in a CRR.

Selection of the type of CRR is based on the psychiatric profile of the child. Children with the most challenging mental health needs can receive individualized services in a host home, with the number of residents and the intensity level determined by the child's need. Children with a higher level of stability and self-sufficiency can make use of CRR group homes. These latter settings can at times prepare the child for independent living, as part of a long-term community plan for the child. Host home CRRs are especially indicated for RTF diversion and as a step-down from RTF or inpatient.

Strengths:

CRRs constitute an extremely important set of service options for children with SED. The host home in particular represents a potential diversion from RTF and at times even inpatient services. The host home also can offer an aftercare setting for those children being discharged from RTF for whom a return home is not yet clinically

appropriate. Since the host home is a home-like setting, this service represents another way to enable a child with SED to reside in the community. In addition, when the host home program works effectively with the child within the context of the child's biological family, the likelihood of a successful return home is greatly enhanced.

Mental health group homes represent an important resource for children with SED whose level of need is less severe than children in host homes. The group home can also serve as a residential resource to prepare an older child for independent living.

Limitations and quality improvement issues:

The primary limitation of both CRR group homes and host homes is their relative scarcity. There are many more group homes for children in child welfare custody, or for children under the supervision of Juvenile Justice, than for children with severe mental health problems. An increase in CRR group home and host home capacity could promote greater clinical flexibility and could perhaps decrease some use of RTFs. In addition, such increased capacity could assist in obtaining appropriate aftercare for children in residential placement who are unable to return home.

An additional limitation sometimes involves a lack of services and supports being offered to the child's biological family, when the child is in a CRR and the long-term plan involves the child's return home. Under such circumstances, treatment for an individual child without concurrent attention to the family of origin and the child's relationships within the family can greatly compromise a successful return home. Host home programs vary in the degree to which they involve the biological family in the child's treatment process and to support them. Best practice involves providing as much attention to the child in relation to the biological family as to the child with the host home parents. In some cases, the biological family also benefits from services beyond the scope of the CRR program. CRR staff should be attentive to unmet needs of the biological family, and can serve as a catalyst for respectful discussions and possible referrals.

Finally, the level of responsibility being placed on host

home parents, who, despite their program-specific training are not mental health professionals, is substantial.

Therefore, appropriate screening is essential and families selected must receive adequate training, supervision, and support. Possible negative preconceptions regarding the child's biological family or the use of psychotropic medication should be identified and addressed. Host home parents, like all parents working with a child with SED, need to learn to respond in a therapeutic manner to behavioral challenges by the child. There is a similar need for ongoing efforts to understand the actual determinants of such behavior, so these can be addressed. When host home parents receive strong professional support, the above goals can be achieved.

Overall assessment:

CRRs represent a mechanism for supporting the community tenure of children with SED with limited family resources or a level of impairment that exceeds their family's ability to manage. The host home in particular may constitute the most effective way to meet the needs of those children whose needs are so individualized that other community-based services are unlikely to support them effectively. CRRs enable some children to avoid institutionalization, while others are discharged from such facilities earlier than would otherwise be possible.

There is clear need for the system of care in all areas of Pennsylvania to develop more CRR options, especially CRR host homes, for children with SED. Greater availability of CRRs can potentially reduce RTF use in the Commonwealth, and might also decrease the revolving door pattern of inpatient service use by some children. Intensive, creative approaches are needed to recruit and maintain host home families, with reimbursements consistent with the intensity of commitment required and ongoing staff support of their committed efforts. Similarly intensive efforts are needed to work with the child's biological family, unless there are legal prohibitions against this, so that the child's successful return to the family home is promoted. Even when the child does not return home, work with the child's family can often be beneficial, in addressing issues of affiliation, loyalty, and personal identity.

7. Mental Health Residential Treatment Facility (RTF):

Description:

The mental health residential treatment facility (RTF) provides 24-hour, 7-days-a-week residential treatment care for children who have not been able to live successfully in the community as a result of their SED. The RTF is less restrictive than psychiatric inpatient. RTFs do not serve as emergency facilities for children in acute crisis, but rather as a treatment resource for children who have demonstrated that they can no longer safely remain in the community. The RTF level of care is typically not invoked until less restrictive interventions have already been tried.

The RTF serves two populations of children: those solely with SED, and those in protective custody of the court with coexisting SED, who require this level of care. The RTF does not serve children in custody for whom medical necessity for this intensive, restrictive mental health level of care has not been established. RTF services are accessed through a comprehensive evaluation and the recommendation of an interagency service planning team. Since 1993, it is no longer necessary in Pennsylvania for parents to give up custody in order for their child with SED to receive medically necessary RTF services.

Children in an RTF receive education in a setting agreed upon by their home school district. Education can be provided in a community school in the RTF's school district, in an on-grounds school operated by the RTF, or occasionally by the local Intermediate Unit. It is expected that the child's educational placement is subject to least restrictive considerations rather than necessarily localized on campus. Since some children with SED are capable of functioning in a community-based educational setting, a child's psychiatric and educational needs should not be automatically equated.

The RTF, although primarily a mental health service, is expected to attend to all needs of a child in placement. This includes addressing the child's substance abuse issues, through on-campus counseling, community referral, and use of self-help groups. The child's medical and dental needs must also be addressed, whether routine or highly specialized.

Clinical indications:

RTF admission is indicated for the child with SED who has demonstrated an inability to function effectively within the community level of care, who does not otherwise require inpatient. Typically, the decision to use RTF is made as the result of a child's long-standing adaptational

problems in the community and a failure of community-based services to address the child's needs. In general, a child should demonstrate global impairment in functioning, not just problems within the family, in order to require the RTF level of care. At the same time, as currently constituted the RTF is not a setting for acutely unstable children in need of psychiatric inpatient stabilization.

For a select group of children—typically those with disrupted caretaking and those with many prior unsuccessful community placements who are in need of diagnostic assessment and/or a change in medication—use of an RTF may also be indicated. Some children require a period of safe harbor with less intimacy than typically found in a home or home-like setting. With such a period of emotional safety in association with active mental health treatment within the RTF, the child may be able to maintain greater community stability—in a family or in a group setting—following residential discharge.

It is important to recognize that most children with SED do not require the RTF level of care, despite what may be considerable psychiatric impairment. RTF care becomes necessary when two factors coalesce: The child has significant impairment due to SED, *and* the community is unable to support the child's continued tenure in the community. In order to restore the child to the community and prevent future re-admissions, the child must be stabilized individually *and* the community-based barriers identified and addressed. These constitute the key parallel tasks of the RTF.

Strengths:

An effective RTF helps to stabilize the child psychiatrically, and also identifies and addresses the specific barriers to the child's community tenure. The RTF also builds on child and family strengths, engages the family and natural supports, places the child in the least restrictive educational setting, uses psychotropic medication as clinically indicated, and focuses intensively on discharge and aftercare issues, not just on the child's conduct within the RTF. There is recognition that the child's permanent home is the community, and that the child must become knowledgeable about the real world, according to age, developmental level, and likely discharge destination. This approach, which involves highly focused, active treatment for the child within the RTF with ongoing family and community connections, has been termed the "way-station perspective" and helps the child develop "real world competence," not just symptomatic and behavioral improvements (Hodas, 1996).

For older adolescents, the RTF can provide vocational assessment and training, either as part of its own services or through referral. Older adolescents who previously discontinued their education have the opportunity to re-engage in school with the goal of regular graduation or, in some facilities, of preparing for the high school equivalency exam (GED). Others can be encouraged to prepare for college and junior college. Comprehensive RTFs combine on-campus substance abuse education and counseling with community services, according to a child's individualized need. Residents with substance abuse problems are encouraged to participate in Alcoholics Anonymous, Narcotics Anonymous, and other self-help groups.

Effective RTF treatment for a child requires more than the concerted effort of the residential facility. There is need for ongoing county involvement, and the active participation of other involved systems. For example, the RTF and county together need to develop ways to recruit families reluctant to participate, and to provide transportation to those interested in participating but unable to get there. The RTF Group in Allegheny County serves as a county-based catalyst for family participation, and works closely with both the family and the RTF throughout the entire treatment process. This represents one innovative model for RTF-county partnership. (The RTF Group, 2002)

Limitations and quality improvement issues:

While there are appropriate indications for the use of the RTF level of care, the Surgeon General's report indicates little evidence-based research in support of RTFs. In addition, while the quality of residential care offered to the child in placement is important, ultimately, the child's post-discharge adaptation depends on the adequacy of aftercare. Treatment generalization and sustainability depend on a variety of factors, including:

- the stability of the aftercare community residential setting;
- the nature of family and other community-based support;
- continuity of mental health treatment;
- consistent use of psychotropic medication, when indicated;
- appropriateness of educational placement;
- development of a vocation or other prosocial sources of income;
- characteristics of the neighborhood and the individual's adaptation to it;
- knowledge of the real world; and
- responses to expected crises.

The culture and expectations of residential treatment are often very different than those within the community. While the outcome of the above variables cannot be ensured during a child's residential placement, there is much that can be accomplished when an alliance is made with the family and community, with efforts made from the outset to address transition issues and prepare the child for discharge.

RTF-level care can be compromised by many factors. These include:

- preoccupation with the child's deficits and a failure to identify and build on strengths;
- the absence of ongoing family participation in treatment and lack of active recruitment of family;
- a tendency to judge or blame rather than collaborate;
- over-reliance on generic levels systems without sufficient regard to the child's individualized mental health needs;
- over-reliance on behavioral outcomes, without sufficient attention to skill development, including the promotion of self-expression, appropriate self-advocacy, and the capacity for emotional reciprocity in relationships;
- lack of attention to substance abuse issues;
- failure to use psychotropic medication, when indicated, or to maximize its use, consistent with clinical need; or use of such medication without clear justification or adequate monitoring of outcomes;
- lack of awareness of the bicultural life experience of many children in residential treatment, which requires consideration of how effective functioning in certain community settings may require modification of mainstream coping mechanisms taught in the RTF;
- unrealistic discharge criteria;
- fragmented treatment planning with other child-serving systems, resulting in delays in aftercare planning and its implementation;.
- limited efforts to promote community integration during residential placement, such as through use of least restrictive educational settings, community jobs, use of therapeutic leave, and intensification of family contact prior to discharge;
- lack of attention to the full educational potential of some residents, who may benefit from SAT preparation and academic placements, not just vocational ones.
- failure to ensure firm aftercare services, including the initial aftercare appointment, and to convey

necessary clinical information to the aftercare provider, including the child's overall progress, response to psychotropic medication when used, and continuing needs.

From the perspective of service capacity, there are additional areas of need involving RTFs. These include the need for more small (8-12 bed), community-based RTFs, where the child more fully experiences community living during treatment, and from which transition to a lesser level of care is often more easily achieved. In addition, in Pennsylvania, there is need for more facilities with specialized expertise in such clinical areas as sexual perpetration, persistent aggression, firesetting, management of children who are brain-injured with behavioral challenges, sexual victimization, and the sequelae of severe trauma. Many of these children are sent out-of-state to receive these specialized residential services. In addition, many children, once adjudicated delinquent, are turned away by in-state RTFs based solely on their legal status, without individualized consideration of their potential appropriateness for the program. As a result, many of these children are also placed out-of-state. There is need for Pennsylvania to more fully take care of its own, within this level of care.

Finally, RTFs are most effective when there is strong psychiatric leadership and the opportunity for comprehensive psychiatric assessment to guide the treatment process. Thus, there is need to ensure the adequacy of psychiatric time within RTFs. Given the level of need of children within this level of care, it is important that the child psychiatrist be available to the child, family, and other team members, provide comprehensive assessments, psychotropic medication and ongoing support for treatment, attend team meetings, as well as interface with other systems.

Overall assessment:

Despite the absence of a strong evidence base to date, the RTF is an important part of the children's system of care and can serve as a valuable transitional resource for

children who have been unable to function successfully in their own homes and communities. It is important to remember that RTFs are relatively new as a mental health service in Pennsylvania, and that most such facilities have longer traditions as orphanages or other child protective residences. A transformation to more active treatment, to address the challenging mental health needs of its children, is underway, but there is need for ongoing statewide, county/MCO and provider initiative, with the input of parents and family advocates, to continue the process. As this occurs, RTFs will be used more effectively to reinforce the community as the natural home of the child.

Typically, an RTF should be used when lesser levels of care have been unsuccessful, with recognition that successful RTF treatment requires ongoing attention to transition issues such as discharge and aftercare, not just the child's functioning within the facility. Since the need for the RTF level of care arises when the community is not able to support a child with severe psychiatric need, it follows that treatment should address *both* the individual needs of the child *and* the associated contextual, community-based barriers. Successful RTF treatment is not the responsibility of the facility alone, but requires the active collaboration of the family, county, and other involved systems.

The RTF landscape in Pennsylvania would be meaningfully strengthened by greater diversity of facilities. This would include more small, community-based facilities, more facilities with specialized expertise, and a greater willingness on the part of many facilities to serve adjudicated youth who might benefit clinically from their programs. The possibility of discrete levels of care within RTFs, to serve children with different levels of need in a more individualized way and more actively promote community reintegration, should also be considered. It is important that there be sufficient psychiatric time within this intensive level of care, consistent with the needs of the population served. The promotion of such diversity and quality requires realistic, individualized rate setting by funding sources, including adequate reimbursement for psychiatric services.

8. Inpatient psychiatric hospitalization (inpatient)

Description:

Inpatient psychiatric hospitalization (inpatient) is the most intensive and restrictive service available. It involves intensive, 24-hour-a-day treatment and monitoring, with full-time psychiatric and nursing coverage. Inpatient treatment can be provided either in a general community

hospital—in units designated for children and for adolescents—or in psychiatric hospitals. There are many more inpatient facilities that treat adults than treat children. While a general goal of the service system is to prevent (and divert, whenever possible) the admission of children to inpatient, at times this level of care is needed.

Most often, the rationale for inpatient admission of children involves concerns about safety—the safety of the child and/or the safety of others. Children may be admitted after an overt act or a series of overt acts, or after threatened acts or other evidence of acute risk. Another source of inpatient admissions involve acute psychotic episodes or exacerbations of a psychosis that cannot be managed in the community. Children may be admitted following an unexpected reaction to psychotropic medication, in order to manage the side effects, restabilize the child, and make necessary medication changes. On occasion, a child functioning poorly in the community may be admitted to inpatient for intensive evaluation and diagnostic assessment.

Clinical indications:

Inpatient is indicated when the safety of a child or others is jeopardized and it is determined that the child's needs cannot be safely managed in a lesser level of care. Reasons may include:

- the absence of a safety contract (or absence of a *credible* safety contract) by the child;
- the acuteness of the clinical situation;
- the failure of prior treatment at a lesser level of care to address issues of concern;
- the absence of sufficient community-based professional and support services to meet the identified need;
- the inability of family and community to provide the necessary support and monitoring.

Other circumstances in which inpatient may be indicated include:

- an acutely psychotic child in need of stabilization;
- an acute reaction to psychotropic medication or the need to control side effects;
- the need for discontinuation of psychotropic medication;
- the need for a new medication trial;
- the need for intensive observation, diagnostic assessment and disposition.

Strengths:

Although no level of care can guarantee safety, inpatient services are justifiably regarded as the most appropriate setting, most of the time, for children whose acute presentation jeopardizes their or others' safety. Within the inpatient setting, the child can be observed intensively, to determine the nature and frequency of symptoms and to assess the degree of improvement. Since the inpatient psychiatric unit has access to physical health

expertise and services as needed, the child can be medicated more rapidly and intensively in this setting than in the community or an RTF. Inpatient treatment makes use of group therapies, creative arts therapies, and therapeutically guided recreation. Individual therapy is offered the child according to age and developmental level, and family therapy may be used.

Limitations and quality improvement issues:

In recent years, length of stay in inpatient has decreased steadily. Whereas stays of many weeks or even months were once common, now a typical stay is 7-10 days or less. While this trend is not in itself problematic, there have been some undesirable effects. With shortened stays, attachments by children to staff, peers, and the program itself have been weakened. It has been difficult to maintain "the therapeutic community"—an intense community-wide process that emphasizes caring, reciprocity in relationships, and a sense of interdependence among children.

Another effect of shortened stays has been insufficient time to determine the efficacy of certain medication interventions. The child is sometimes discharged before there has been time, for example, for antidepressant medication to begin working or before other medications have reached therapeutic blood levels. Although such premature discharges are less common in the public sector than in the commercial realm, it is questionable whether they benefit the child and are cost-effective in any funding system.

As hospital stays have shortened, involving the family meaningfully in treatment has become more challenging. Some facilities do involve families, while others have not made the philosophical shifts and logistical commitments that are preconditions for family participation. The goal with inpatient services, as with all services, is for families to be equal partners in treatment. However, in some cases parents receive few contacts from professionals other than administrative questions and information about the child's probable discharge date.

An inpatient facility must be "family-friendly." This involves providing education and information about the child's disorder and treatment, and support for the family's caretaking efforts and struggles. Beyond this, families should be given the opportunity (not coerced) to participate in family therapy sessions, which may be especially productive during this heightened period of concern, and should also be encouraged to participate actively in strategic treatment decisions and their monitoring. Inpatient admission, regardless of its length, can also be a period during which a team can assemble or reassemble, and

develop plans to support the child's successful reintegration back into the community.

For an inpatient admission to contribute to a child's long-term well being, continuity of care is needed. Such continuity begins with use of the same inpatient facility for the child for all treatment episodes requiring this level of care, unless there is a specific reason to use a different facility. Continuity is also promoted when the inpatient facility contacts the community-based team, including the treating psychiatrist, to learn about the child and to convey current information about the child's hospital treatment and adaptation. The inpatient psychiatrist and other hospital staff need to work closely with the child's case manager, community-based therapist, community-based psychiatrist, and family throughout the entire admission. Continuity of care is seriously compromised when an inpatient team operates in isolation. The opportunity to explore and address key issues may be lost. At times, the child's medication may be changed without a prior medication history from the outpatient psychiatrist and without knowing the outcomes desired from the hospitalization by the community-based psychiatrist, or even the specific reason that the inpatient level of care may have been actively sought.

Overall assessment:

The inpatient hospital is the most restrictive and most intensely staffed mental health service available. Although

children in crisis can sometimes be treated in the community, it is good to know that the inpatient option exists and is available when needed for a child whose level of impairment severely jeopardizes the safety of self and/or others.

The duration of inpatient stays has been decreasing for both children and adults, and this means that time is at a premium. If a community team needs to form or reorganize, this should proceed rapidly. Similar considerations apply to medication trials. Such pressure does not always benefit the child, however, and at times inpatient discharge occurs before the effectiveness of new medication can even be determined. There is need for outcome data to determine what duration of inpatient treatment is most associated with successful transition to the next level of care.

As a general guiding principle, inpatient hospitalization needs to be constantly conceptualized as an intense but brief interruption of a child's community care. With this mind-set, good communication and planning involving inpatient and community-based practitioners can enable the child's admission to be beneficial on both a short-term and long-term basis. Consistent with this longitudinal perspective, inpatient facilities need to support the time needed by their psychiatrists to prepare comprehensive reports that recommend medically necessary aftercare services for the child.

Additional Services

In addition to the services previously reviewed, which represent a continuum of services for children based on the level of restrictiveness needed, there are additional services for children to be considered below. These services lie outside the continuum of care based on restrictiveness, and can be used at any time to support the effectiveness of the primary services. Included in this group are the following:

1. Family support services
2. Student Assistance Program (SAP)
3. Case management services

4. Summer Therapeutic Activities Program (STAP)
5. Crisis intervention and emergency services
6. Miscellaneous ad hoc services

SAP is included among the additional services, given its mental health component for students in crisis and at-risk, even though it is a school-based program and does not require establishment of medical necessity from a mental health source to be used. All of the other identified services require establishment of medical necessity and serve a complementary but crucial role for the child and family.

1. Family support services

Description:

Family support services consist of a constellation of family-driven, formal and informal services and tangible

goods that support the family's efforts to care for and live with a child with SED. Family support can be applicable to either a natural or foster family. Family support can also be used to help families maintain contact with a child in out-

of-home placement, and to support the family upon the child's return home. As with all services, the identification and implementation of family support services must be consistent with CASSP Principles.

Family support services, due to the breadth of this concept, can come from multiple sources, and can also be a component of specific categorical services (for example, information and education, which is a family support service, may be provided by a case manager, BSC, child psychiatrist, or other service provider). Given that the more tangible family support services are not MA-reimbursable, many family support services come from a discrete pool of county funds, which has historically been limited. Not all counties, however, separate family support funds from other revenue. One categorical service, FBMHS, has family support services—including tangible goods and cash assistance, when indicated—built into its program design.

Family support services can include any of the following (Family support services, 1993):

1. Self-help advocacy groups, which enable families with a child with SED to learn from and empower each other.
2. Sibling support groups and resource development for siblings, so that the needs of siblings of a child with SED are not overlooked.
3. Information and referral, to help the family identify and access natural supports.
4. Education and training, addressing such issues as community resources, legal and financial entitlements, diagnostic and treatment information, and skill building.
5. Advocacy on behalf of a family, during formal meetings and at other times, as determined by the family and including such individuals as extended family, spiritual leaders, and other parents.
6. In-home and out-of-home respite, to provide a break for regular caretakers on both a planned and unplanned (e.g., emergency) basis as needed, to include variable time intervals and different settings.
7. Supports to families in using informal systems that exist within the family's neighborhood and culture, including community and spiritual leaders, neighbors, extended family, and peers.
8. Supports to generic community programs, so that these programs can include the participation of children with SED. Generic community programs may involve art and music lessons, sports, scouting, and programs offered by cultural and learning institutions.
9. Special recreation programs, which involve the range of generic community programs, but targeted specifically to children with SED. Such programs can be available after school, weekends, and summer, and seek to promote social skills, problem solving, peer relationships, constructive use of leisure time, and better understanding of the disability.
10. Day care, available when the parent works or attends school, with a focus of promoting the child's social, cognitive, and emotional growth. Day care includes nursery school and preschool programs as well as programs that serve the child before and after school.
11. Cash assistance and tangible goods, which may include play equipment and educational materials for the child, household furnishings or repairs, and items related to the child's cultural background.

Clinical indications:

Given the broadly-based conception of family support services, there are many possible indications for this service. Many family support services are not hard services and do not require the categorical allocation of money. For example, every child and family can benefit from information, without which specific services are likely to be of limited benefit. Similarly, the linkage of the family to natural supports is an important aspect of treatment planning. Self-help and support groups can be invaluable for the child and the family. Support and advocacy for the child and family reduce the complexity and intimidation of "the system" and promote child and family participation in treatment.

Generally, with specific, concrete family support services, counties determine the criteria for the availability of day care and the allocation of cash assistance and tangible goods. Respite services represent one important concrete family support service. Respite services are indicated when a family is in need of discrete periods of time off from direct responsibility for their child with SED. Respite serves many functions for families, by providing time and an opportunity for emotional refueling and supporting the child's community adaptation. Specialized recreation programs are indicated when they address specific needs identified in the child's treatment plan. Some

special recreation programs, such as STAP, can be accessed through a separate funding stream.

Strengths:

As can be seen from the above list, family support encompasses a broad range of services and supports for the child and family. For example, the self-help advocacy group can provide a perspective to parents that is different from those of mental health professionals, and may enable the family to be more receptive to, and make better use of, professional services. Similarly, information and training are building blocks of empowerment, and family support addresses these elements. For an overburdened family, respite services can make an enormous difference, providing time for the family to tend to other needs and refuel itself, and often decreasing the child's potential need for higher levels of care. The theme of natural supports runs through many identified family support elements. Natural supports are a complement to professional services and, over the long run, help the family sustain its progress.

Some family support services also constitute specific services that can be accessed for the child. For example, special recreational services for a child with SED can be accessed through a Summer Therapeutic Activities Program (STAP), which is considered a part of BHRS. Similarly, afterschool programs can also be accessed for the child.

Limitations and quality improvement issues:

Elements included under the umbrella of "family support services" are all vital to families, but not all are easily obtained. For example, there is a national day care shortage. In addition, "respite" is a wonderful concept but it is not an MA-reimbursable service or subject to a federal match, which makes it difficult to obtain within mental health. Respite is more accessible for children involved with Children and Youth and the Office of Mental Retardation, which does not benefit the family of a child with SED who is not involved in those systems. The issue becomes one of funding, both in Fee-for-Service and managed care.

From where will family support dollars come, and how will they be made available in case-specific situations? Generally, as discussed, family support funds come from counties, but the extent of resources and specific arrangements vary greatly. This may mean that, in some

cases, family support services are more theoretical than real.

Overall assessment:

The concept of family support is extremely important for a system of care that seeks to be flexible, individualized, and family-centered. Family support services are intended to fill some of the "cracks" that may not be addressed by the more direct professional services in the service array. Actually, we have seen that some family support services can be accessed as specific services for children with SED. Other family support services are not really "services" at all, but part of a vast array of natural supports. In addition, some identified family support functions are also addressed by professional service providers. For example, part of the role of a targeted case manager involves provision of information and referral, education, and advocacy. The case manager may also have information about cash assistance and tangible goods, and may be able to help the child gain access to community programs. This overlap is not problematic and in fact is desirable, since it is beneficial for the family to have many avenues for information, natural supports, and services.

A question remains for mental health and the Office of Medical Assistance Programs. If respite is recognized as important—and it can make the difference in some cases between a child being able to be maintained in the home or eventually requiring out-of-home placement—how can this support be made more easily available? Is it possible for children with SED and their families to gain greater access to respite, which has been identified by families and family advocates as a very high priority? How can counties expand family support service funding, and how can such funding be made available equitably? Are there other creative ways to expand and obtain family support services for more families? Given family need and the fact that, compared to categorical services, family support services are very limited in cost (yet often unlimited in value), there is clear need to expand family support service capacity.

Finally, there is another possible type of family support service that to date has had limited implementation in the state. This involves the potential engagement of successful young adults with a similar disorder who are recruited to become part of the child's treatment team. Such programming, for example within RTFs, might effectively complement the current involvement of family members and advocates in a child's treatment team and in the broader system of care.

2. Student Assistance Program (SAP)

Description:

The Commonwealth Student Assistance Program (SAP) is a school-based program that includes a mental health component that, by virtue of its history and funding stream, is considered separately here. SAP, which initially began in 1984, is a program for at-risk high school students. These students are identified, provided educational and group services as appropriate, and offered referrals when indicated for appropriate services—mental health, substance abuse, or both. Community mental health and drug and alcohol SAP liaisons also provide consultative functions with teachers and other educators within their schools of assignment, and may help the school address specific issues (for example, adolescent suicide attempts and cultural competence) that are of general relevance to the school community.

SAP is a Commonwealth program that is supported programmatically by three Departments—Education, Health, and Public Welfare. It operates on a regional basis and its services are available in every school district within the state. Each secondary school building has a SAP core team that functions in collaboration with parents. The core team consists of school personnel (teachers, counselors, principal, nurses, psychologists, etc.) and SAP community liaisons. The latter are trained in both mental health and substance abuse, and they establish referral networks to local providers. While respecting the confidentiality rights of adolescents, SAP staff are committed to working with families.

Clinical indications:

Programmatically, given its focus on consultation, prevention and screening, SAP is mandated for every secondary school building within every school district in the state. SAP intervention is indicated to provide a range of specific functions, as defined by the school and its core team. These can encompass such activities as normative educational workshops, crisis groups and intervention, and intervention with individual students.

Individual students should receive SAP attention when they are identified by teachers, guidance counselors, parents, peers, others, or self-identified as having—or at risk of having—a mental health or substance abuse problem. Since the goals of SAP for individual students primarily involve assessment, education and referral, the role of SAP staff is often a facilitative one for the child in need of more intensive intervention.

Strengths:

SAP has important liaison, educational, and triage functions within the schools. By providing a perspective complementary to educators, SAP community liaisons can help the community deal with expected developmental issues and unexpected crises. SAP has identified many children statewide who are at-risk and has made many referrals for mental health and substance abuse services.

Limitations and quality improvement issues:

Currently, as the state implements mandatory behavioral health managed care, it is clear that SAP needs to continue to be a school-based community resource. Managed care is not responsible for funding SAP, but there are nevertheless new challenges to be addressed. For example, whereas in the past the evaluation completed through SAP led directly to service provision, now the behavioral health managed care organization (BH-MCO) may not have credentialed the SAP evaluator and may require another evaluation prior to making a service decision. While this process is not intrinsically problematic, it can slow service access. Coordination of effort is needed here, to ensure timely provision of medically necessary services by the BH-MCO for vulnerable children identified by SAP. Mechanisms for coordination should be developed, perhaps including the credentialing of many SAP evaluators by managed care.

It is also important that SAP funding parallel the need for this service. With increasing need by many adolescents for SAP intervention and the growth of the program, current staffing patterns are not necessarily adequate and funding increases may be needed. In addition, increased funding could also support the further availability of SAP for elementary school students, a group where prevention can make a significant difference.

Overall assessment:

Unlike other services previously discussed, SAP is not primarily a treatment service. For some students, SAP-facilitated psychoeducational groups provide benefit and no further services or referrals are needed. For other students who are at risk and/or symptomatic, referral for mental health services or substance abuse services is necessary. SAP can be viewed as part of the “safety net” of education in Pennsylvania, and should continue to receive ongoing support.

3. Case management services

Description:

Case management services in Pennsylvania are non-clinical services designed to assess, coordinate, and access services and supports needed by the child and family. Studies with adults have repeatedly shown that mental health case management services, along with mobile crisis services, are highly effective in promoting community adaptation and reducing use of institutional care. As such, they are cost effective and often decrease the need for additional services. Although less well documented, there is reason to believe that case management services promote similar outcomes for children and their families.

Pennsylvania has identified three levels of mental health case management, based on intensity of need:

- administrative case management (the least intensive);
- resource case management (RC, of intermediate intensity with a requirement of hands-on involvement);
- intensive case management (ICM, the most intensive level).

Both RC and ICM are designated as Targeted Case Management (TCM), and are accessed from the county of residence. Since the county funded TCM separately and had to pay the state portion of this federally funded program, there have in the past been shortages of this essential service. Under HealthChoices, TCM is an in-plan service.

The mental health case manager represents a link of continuity, especially for the child who moves through different services and/or levels of care. The case manager is also expected to be attentive to the needs of parents and the family as a whole, and can offer referral options and suggestions when requested or indicated. The case manager provides oversight of other services being offered to the child and family, and helps coordinate care. As such, the case manager provides an important quality function. The case manager can provide ongoing support and assistance to the child and family and, when indicated, intensive outreach. When there is a problem between the family and a service provider, the case manager can often intervene and help resolve the problem.

A notable specialized form of mental health case management services is employed in Allegheny County, where an oversight group has been established for children placed in RTFs. Known as the Allegheny County RTF Group, it serves many important monitoring and other case

management functions. The RTF Group, in addition to screening referrals to RTFs and reviewing the indications for continued care, ensures that there is ongoing family participation while the child is in the RTF and that the treatment plan is implemented as written. Another function involves ensuring that discharge planning begins early and occurs in a timely manner, with availability of aftercare services upon the child's discharge, so that continuity of care is not disrupted (RTF Group, 2002).

Clinical indications:

Mental health case management is indicated for the child with SED who is involved with multiple systems or receiving a variety of services. This may include a child with mental health and physical health needs, mental health and substance abuse, mental health and mental retardation, and other combinations. A child whose level of severity is such that BHRS is needed typically should receive case management, as should a child transitioning from an RTF back to the community. When more than one program office or system provides case management services, the team needs to determine which individual assumes the role of lead case manager.

Strengths:

The mental health case manager plays an indispensable role for children with SED. The TCM is the closest that Pennsylvania has come to providing unconditional care to children, since the service typically continues after substantive treatment services are discontinued, until the child no longer needs this level of support. Because this service is often long-term, the case manager frequently has strong relationships with the child and family and considerable influence. For these reasons, the case manager also serves many indirect functions, including that of a morale booster for the child and family and a source of support during stressful times and times of actual crisis. By interfacing with different systems and serving as a service broker for the child and family, the case manager promotes holistic care for the child and service coordination within the child's helping system.

Limitations and quality improvement issues:

Historically, the greatest limitation involving Targeted Case Management has been limited access. Its county-based funding prior to HealthChoices created scarcity and waiting lists. Under HealthChoices, requests for TCM often go the county rather than to the BH-MCO, but TCM is an in-plan service. Given the importance of TCM for children,

many counties have made its availability a priority.

Despite this progress, access to mental health case management still remains a problem for many children in the RTF level of care, and sometimes for those transitioning from inpatient back to the community. Children in RTFs in particular need some form of county-based case management, to complement the treatment and case management efforts of the treating facility. Two different approaches could address this need. The first involves the use of county-based case managers who continue to work with the child during the RTF treatment period or are assigned to the child, following RTF admission. The second involves the use of RTF-specific case managers, who become involved following the child’s admission and remain active until the time of discharge and transfer back to community-based case management. The latter is the approach used by Allegheny County’s RTF Group. Each approach has potential advantages and some limitations. What is important is that children in RTF receive some form of county-based mental health case management, which can support active treatment by the facility, ongoing family participation, and appropriate discharge planning and aftercare implementation.

From a quality perspective, the effectiveness of any service, regardless how conceived, depends on the functioning of the individual fulfilling that role. This is especially relevant for case management, given the case manager’s responsibilities as “trouble shooter,” support to child and family, and overseer of quality. An active approach to case management, with the case manager positioning himself or herself at the center of the action, is essential. This includes being proactive with team communication and service oversight, as well as undertaking ongoing efforts to learn about community resources and the values and preferred practices of the individual child and family.

Helping the family to identify and recruit individuals from the community to serve as part of the child’s interagency service planning team (ISPT) constitutes another component of case management leadership. Still another involves skillful facilitation of ISPT meetings, in support of active participation by all parties, collective recognition of child and family strengths, and attainment of a sense of common purpose. In further support of team functioning, the case manager can distribute meeting

summaries, offer team members reminders of pending meetings, and provide assistance with transportation, when needed. Finally, the active mental health case manager recognizes that the need for oversight and coordination extends beyond just mental health, to include all systems involved with the child.

Overall assessment:

Mental health case management is an essential non-clinical service for children and families that provides some of the glue to enable clinical services to be effective. Case managers, particularly Targeted Case Managers, typically support the child and family for substantial periods of time. Mental health case managers offer treatment continuity for children and their families and help them navigate both the formal service system and a range of community resources. Valuable during routine times, the mental health case manager becomes especially important to the child and family during times of crisis and/or service transition. Mental health case managers are in an ideal position to help a family identify and expand its team – so that it includes extended family, neighbors, community leaders, and other community resource persons identified by the family. Such an extended network, once developed, serves as an important link for the family to the community at large, broadening the scope and influence of the team. Finally, mental health case managers can provide direct leadership in support of the treatment team, through skillful meeting facilitation, circulation of meeting summaries, reminders of pending meetings, and assistance with transportation.

Given the importance of mental health case managers, it is important that all of them receive training commensurate with the scope of their critical role with children and families. They should be encouraged to serve as a catalyst for child and family team building and as effective team meeting facilitators. They should maintain a proactive role in promoting team communication, overseeing mental health service quality, and looking at the “big picture” for a child involved with multiple systems. Counties should support the provision in some manner of case managers for children in institutional care, in order to promote active treatment and successful transitions back to the community. Overall, the children’s service system should ensure that mental health case management is readily available when indicated, since its impact is synergistic to specific clinical services.

4. Summer Therapeutic Activities Program (STAP)

Description:

The Summer Therapeutic Activities Program (STAP) is a specific BHRS within the array of services for children with SED. Because it is frequently overlooked as a BHRS and because it offers service for a discrete time period every year (the summer), it is considered here separately. STAP is a rehabilitative summer program for the child with SED who is likely to lose ground over summer months without the structure usually provided by school. Potential consequences include both the loss of specific gains and a more serious regression, with possible need for more intensive services. STAP provides a normalized peer setting with a variety of activities found in generic summer camps, but adds professional staffing to support attainment of the child's individualized therapeutic goals, as identified in the treatment plan.

Most STAPs run for five consecutive summer weeks, but there is some variability. Hours vary from 3-6 hours a day, and the service is available a maximum of five days a week. Expectations are that the service is provided in a manner consistent with CASSP Principles, with a staff committed to child-centered service delivery. Specific staffing patterns and ratios have been identified.

Since April 1996, STAP has been on the MA Fee Schedule, pending approval of each provider's service description by OMHSAS. Once the service description is approved, the provider can access STAP directly off the Fee Schedule when medically necessary for a particular child, without a requirement of prior approval. Within HealthChoices behavioral health managed care, STAP is an in-plan service and requires prior approval. The BH-MCO is responsible for offering STAP for children under its care, when requested and documented to be medically necessary.

Eligibility for STAP, as with any BHRS, includes an MA-enrolled child with SED, up to age 21. Medical necessity is established via a psychiatric or psychological evaluation and individualized treatment plan resulting from an interagency service planning team meeting that includes participation of family and relevant child-serving system representatives. The treatment plan is expected to identify specific goals and objectives for the child to achieve during STAP program time. Goals for STAP should be incorporated into a single clinical treatment plan for the child.

Generally, STAP programs are expected to include the following components:

- group and individualized programming, to meet the identified needs of the child during the summer months;
- family participation in treatment planning and in STAP;
- integration of clinical information gained from the child's STAP participation into ongoing educational and mental health programming, via information sharing with the treatment team.

Clinical indications:

A STAP is indicated for the child with SED who is identified as likely to lose ground over the summer months, given the absence of the structure usually provided by the school. Possible consequences include the loss of specific gains, emotional or behavioral regression, and the possible need for more intensive services. A clinical indication for STAP may involve a need for the child to learn to function more effectively in group situations with peers. STAP should not be used when the child has been in partial hospital until the end of the school year and the more intensive partial setting continues to be the more appropriate service for the child. Children with appropriate community resources and not in need of a therapeutic summer program should not attend STAP. The older adolescent able to obtain community employment and to engage in a county-based or other community recreational program should also not require a STAP. Although there may be exceptions, STAP typically should not be the initial or sole mental health service received by a child.

Strengths:

STAP addresses the service gap experienced by many children with SED during the summer months, a gap that jeopardizes their progress and places them at risk of regression. It is not appropriate to place a child in a partial hospital program during summer months, based on the absence of school, when the child does not otherwise require this level of care. STAP comprises a less intensive and less restrictive psychosocial rehabilitation service for children with SED during the summer.

STAP, as a summer psychosocial rehabilitation program rather than a structured education program, often offers children the opportunity to progress more freely with peer socialization, community integration, and constructive use of leisure time than during time spent in formal education. STAP potentially represents an opportunity to promote normalization and psychosocial development,

while also addressing the child's specific mental health issues through the use of a structured treatment plan.

STAP typically uses three classes of child-centered, therapeutic interventions:

1. Structured therapeutic group activities—traditional and specialized—that seek to promote child-specific skills such as interpersonal skills, coping skills, daily living, problem-solving, and decision-making.
2. Community integration activities, to assist the child in developing appropriate behaviors and responses in the community context.
3. Other child-centered interventions, including individual and group therapy, which vary according to the individualized needs of the child.

Limitations and quality improvement issues:

Because STAP is a summer program only, there can be a lack of cohesiveness when staff engaged for this program do not know each other and are unfamiliar with the operations of the provider. In addition, since some STAP programs accept children not otherwise receiving services from the STAP provider, it can be challenging for staff to become familiar with all of the children rapidly, as truly individualized programming requires.

These challenges reinforce the importance of meaningful interagency planning for each child identified for STAP. Since most children participating in STAP are already receiving behavioral health services, it is essential that the treatment plan identify the child's strengths, needs, progress to date, and specific goals and objectives. The treatment plan should then be expanded to include STAP-specific goals and objectives, unless pre-existing goals and objectives are already applicable to the child's STAP participation.

When STAP is not effective, it is typically due to a lack of cohesion among program staff, along with a lack of individualized response to participating children, which may be a result of vague or overly general treatment plans. It is easy for staff to focus on issues of control, obedience and group behavior, and overlook each child's unique needs and specific treatment plan objectives. Programming needs to build on the characteristics of the target population, the strengths of the provider, and needs of the specific child. Thus, it is expected that programming may change from year to year and even over the course of a summer, rather than remain static and invariable. It is also essential that programming build on the strengths and

competencies of the child to promote adaptation and psychosocial development, rather than dwelling on areas of limitation. STAP should also promote the child's community integration and citizenship, including social skills and the capacity for the peaceful resolution of conflict through respectful interpersonal problem solving.

Finally, there are access issues related to STAP, since there is limited availability of this service in some parts of the state. As an identified mental health service within the Fee-for-Service system and an in-plan service within managed care, STAP should be available for every child for whom it is medically necessary. Unfortunately, some portions of rural Pennsylvania and other areas do not currently have STAP, and capacity building there is essential. In some areas where there is a history of STAP programming, counties are focusing efforts on providing opportunities for children with SED to participate in regular summer camp programs. While this is consistent with the principle of least restrictive service use, not all children are able to integrate into regular camps and not all families support this approach. It is therefore important that STAP remain available for those children in need of it, so there is a continuum of summer services that includes a viable STAP option.

Overall assessment:

STAP is a service that provides psychosocial rehabilitation with concomitant preventive elements, since many children with SED are vulnerable to decompensation during summer months, when the structured routines of school are absent. Effectively delivered in an individualized manner by cohesive and child-centered staff, STAP offers the child an opportunity to develop recreational/leisure skills that may be less easily acquired in the school setting during the academic year. STAP enables the child to relate to peers in a less pressured environment, and can reinforce such skills as respectfulness, age-appropriate relating, and peaceful conflict resolution.

The mark of a successful STAP is that it not only provides a rich array of activities, with field trips as well as on-site activities, but it also supports the unique goals and objectives of each participant. In this way, the program serves, at a more fundamental level, as a vehicle for individualized interventions. A successful STAP is guided by daily attention to each child's treatment plan, with the child's goals and objectives posted within the program and a part of the daily staff dialogue. Under such circumstances, both the child and staff can readily identify the child's goals and objectives, and staff progress notes reflect these same issues. An effective STAP incorporates meaningful family participation and addresses relevant

cultural issues. Clinical outcomes are tracked systematically, and child-specific information is conveyed to the child's team at the end of the program, maintaining treatment continuity and ensuring that valuable information is shared.

In HealthChoices counties, managed care needs to help oversee a safe and productive summer for children identified as having SED. Since STAP as developed

initially by DPW represents only one specific program design, there is room for a variety of summer programs for children with SED, with varying degrees of acuity and need. This could include programs less intensively staffed than STAP, delivered in community sites, as well as regular summer camps for those who can benefit from such a normalized experience. It is important, however, that STAP remain a viable service option for those who need it.

5. Crisis intervention and emergency services

Description:

Crisis intervention and emergency services are available to a child and family on a 24-hour basis to address unexpected events, particularly a crisis. For children already in care, these services tend to be used during evening and weekend hours. For children not in care, emergency services may be used at any time, and unfortunately may constitute an inadequate substitute for ongoing treatment. Emergency services are organized in a variety of ways, according to county, local community, or the BH-MCO operating in concert with the county. A children's psychiatric emergency room may be located at a specifically identified general hospital, at a general children's hospital, or at a designated base service unit or other facility. The child is evaluated by a physician, often but not always a psychiatrist or child psychiatrist. The goal is to rule out organic illnesses and possible drug intoxications, determine if the child is in need of acute hospital care (pediatric or psychiatric), and make an appropriate recommendation and disposition.

Crisis intervention can be provided through means other than an emergency room, again depending on the unique characteristics of the local system of care. Many communities and public sector managed care use mobile crisis services that are available 24 hours per day. Mobile crisis teams tend to be multi-disciplinary in nature. If a psychiatrist is not part of the team, the team typically has immediate access to one. The goal of the mobile crisis team is to respond rapidly to immediate needs, and to triage service needs.

When the mobile crisis team determines the child to be in need of formal evaluation for possible acute psychiatric admission, the family is guided in this direction. When there are pre-existing care providers, linkage with them needs to occur. For children not already receiving mental health services, the goal is to serve as a catalyst for engagement and referral. In addition, these services can be

used as a dramatic form of outreach to children and families who have not kept appointments, where problems with engagement and/or reality-based factors create barriers to treatment. Under such circumstances, crisis services need to help the child and family reconnect to ongoing services.

Clinical indications:

Crisis intervention services may be used within any level of care other than inpatient (which addresses crises internally), whenever issues involving safety of the child or others arise. Timely use of crisis intervention services, whether mobile or through an emergency room, can prevent morbidity and mortality and increase the likelihood of problem resolution without resort to a higher level of care. It is important for families to recognize that use of crisis services does not create a stigma or imply incompetence. Crisis intervention services are part of the service array because any child and family, at a particular moment in time, may need them. Crisis intervention services must be available to the child and family based on their perception of need, without a requirement of prior authorization or other administrative barriers.

Strengths:

As a contingency option for both those receiving mental health services and those without such services, crisis intervention and emergency services are essential. As discussed, effective crisis intervention can reduce both mortality and morbidity, and also decrease the intensity of services subsequently needed. In-home crisis intervention, in particular, can be a source of valuable information for an office-based clinician. The availability of these services, along with case management when in use, reduces the sense of isolation of some children and families.

Limitations and quality improvement issues:

A crisis intervention, by definition, meets the child and family at a time of great upheaval and uncertainty. If the professional response is supportive and respectful, it can be quite validating. If, on the other hand, the contact is rushed (due, for example, to inadequate crisis services to meet the predictable needs of the community), or if the intervention focuses exclusively on "pathology," then the family may be disenchanted and a unique opportunity to make a difference will be lost. A home-based crisis intervention is likely to be experienced as unhelpful if there is an excessive interval between the time of the call and the arrival of the mobile team. In the emergency room, long waiting times have a similar negative effect.

A limitation of emergency services, when referral for psychiatric hospitalization is deemed medically necessary, sometimes involves lack of attention to continuity of longitudinal care. Quality care requires concern with both the acute episode and longitudinal care management. In general, the child's care is most effectively managed when treatment comes from the same provider system over time, since practitioners then have access to detailed information about the management of past episodes. Unfortunately, sometimes a child in need of psychiatric admission is hospitalized at whatever facility has a bed, even if the child has been treated at a different facility in the past. While such dispositions may at times be necessary, it is not always clear that treatment history is part of the information upon which a disposition is made. The result

can be fragmented care and less than optimal outcomes. Within managed care, it is essential that care managers attend to continuity of care and the integrated management of the child over time, beyond the treatment of discrete, acute episodes.

Finally, although understandable given the emergency nature of the service, too often the outcomes of crisis and emergency room interventions are not communicated to the therapist or involved psychiatrist. As a result, information about the most vulnerable interval in the child's and family's recent experience may be lost. Every effort should be made by crisis staff to connect with the child's providers, and to simplify the process of follow-up and engagement for those not currently in care.

Overall assessment:

The role of individual emergency team members and emergency personnel cannot be overemphasized. If these individuals are welcoming, the intervention is likely to go well. If, on the other hand, they are impatient, harried, or unsympathetic, the experience may have negative consequences. Crisis intervention is not a service for every clinician, particularly those who require more sustained time intervals in order to form strong relationships. Effectively delivered, these services constitute an important part of the safety net for a child and family, and can help preserve safety, divert from unnecessary use of restrictive levels of care, and serve as a catalyst to ongoing community based treatment.

6. Miscellaneous ad hoc services

There are other mental health services, whose service descriptions have been approved by DPW (Fee-for-Service) or DPW and a BH-MCO (managed care). An example involves a variety of afterschool programs for children. These programs are not partial hospital programs but independent mental health programs for children with SED. Some have special emphasis, such as the creative arts, while others are more general programs for children who do not require the partial level of care but who can benefit from the structure and socialization of an afterschool mental health program. There are other mental health services still being offered that were initially approved by OMAP in the early 1990s, when service descriptions were

first solicited. There are also some services based on service descriptions submitted more recently, although it appears that the expansion of the array of services has been modest overall in most counties. While this paper cannot identify all of the ad hoc services that are in place statewide, it is extremely important for families, case managers, and others to become familiar with all the service resources available in their county and local communities. It is also important to recognize the opportunity to create new services, and to expand the availability of beneficial services and programs, such as multisystemic therapy (MST), which have been used in limited areas (see Henggeler, 1998).

**FORMULATING THE PRESCRIPTION/SERVICE SELECTION:
GUIDING QUESTIONS FOR EVALUATOR AND TEAM**

Ultimately, the authorization of requested services is based on medical necessity, which in turn is based on specific DPW-developed or DPW-approved criteria. Some BH-MCOs have chosen to adopt the DPW criteria (often referred to as “Appendix T” from the HealthChoices Request for Proposals). Others have developed their own criteria, which are then subject to DPW review and approval. Current medical necessity criteria primarily address the level of psychiatric impairment of the child.

The focus of this paper has been to recognize that, while the level of psychiatric impairment is the single most important determinant of mental health need, it is not the *only* determinant. Other factors also become relevant when determining the best service response for a child with SED. In addition, a sound process involves information, participation, and consensus. Still needed, however, is a schema or methodology to help a prescriber or team determine the most appropriate service for a specific child and ensure that the overall process encompassing evaluation, team function and treatment recommendations has *integrity* (i.e., is clinically sound and consistent with CASSP Principles, and has the genuine commitment of the stakeholders).

Below are six areas of inquiry for an evaluator and prescriber of mental health services to consider in making service recommendations for a child. These areas are equally relevant to members of an interagency team. With each area of inquiry are specific guiding questions to be considered. Taken as a whole, this schema can assist prescriber and team in determining what services to recommend for a specific child with SED. The schema is no panacea, however, and will be only as good as the analysis that goes into answering each question. It should also be appreciated that what follows is intended to complement, not replace, the use of formal medical necessity criteria.

The areas of inquiry are:

1. adequacy of information,
2. clarity of clinical understanding,
3. natural supports and family participation,
4. level of care and specific service selection,
5. service intensity,
6. additional individualized recommendations to promote quality treatment.

Areas of Inquiry	Guiding Questions
Adequacy of information	<ul style="list-style-type: none"> • Have I obtained and incorporated information from the referral source and team? • Have I read available records? • Have I listened carefully to the child and family? • Have I identified both strengths and needs of child and family? • What was the past response to treatment, and how invested in receiving treatment are child and family now? • Does my information form the basis of a comprehensive report?
Clarity of clinical understanding	<ul style="list-style-type: none"> • Do I have an understanding of what is going on? • Have I considered the clinical situation from a full biopsychosocial perspective? • Do I understand the problem from the point of view of the child and family, and do I understand their desired, envisioned outcomes? • Do I have a hypothesis to explain why the child is struggling (and why treatment is stalemated, if applicable)? • How can I best address possible demoralization and promote resiliency and engagement in treatment?
Natural supports and family participation	<ul style="list-style-type: none"> • Have I, with the assistance of the child and family and others, identified natural supports for the child and family, to complement the professional services? • How can I best support the participation of the child’s parents or guardian, and other available family members? • As treatment progresses, is the use of natural supports increasing?

Areas of Inquiry	Guiding Questions
<p>Level of care and specific service selection</p>	<ul style="list-style-type: none"> • Have I recommended the most appropriate level of care for the child, given the degree of need and the available resources and supports—e.g., least restrictive/least intrusive level of care? • Is my service selection consistent with the hypothesis regarding the nature of the problem and how best to address it? • Is my service selection consistent with the progression of treatment to date, including specific treatment outcomes, and with the anticipated progression of treatment over time? • Am I bundling services unnecessarily, or is there a necessary and distinct function for each service that I recommend? • Are the intended settings and functions for each service clear?
<p>Service intensity</p>	<ul style="list-style-type: none"> • Is the recommended intensity for each service consistent with the intended role of that service? • Does each requested hour of the service make a clinical difference for the child—e.g., why is this intensity appropriate, rather than one hour less or one hour more? • Does the recommended intensity of services allow leisure time for the child, and an opportunity for normalized living and independent problem solving for the child and family? • Is the rationale/justification of the service request (level of care, specific services, and intensity) clear to me and the child and family, and likely clear to others who will be involved in the care or its authorization? • Do child and family understand that services are ultimately intended to promote self-sufficiency?
<p>Additional individualized recommendations to promote quality treatment</p>	<ul style="list-style-type: none"> • Have I offered additional recommendations, as appropriate, to strengthen the treatment process, or are my recommendations limited to prescribing services in need of approval? • Based on what I have learned, what are my recommendations regarding: <ul style="list-style-type: none"> — treatment strategies and next steps — referrals — natural supports — service integration — psychotropic medication — selection and monitoring of outcomes — promoting child and family self-sufficiency — service tapering, and a plan to transition the child to next level of care or discharge — other ideas for service providers

As can be seen, the above schema offers a conceptual process that can assist with child-specific service selection, which also assists in overseeing the integrity of the entire treatment process. Therefore, it is likely that systematic reliance on the above questions will promote not only appropriate service selection but also effective treatment for the child.

The above process does not, however, offer a systematic basis for determining precise service responses, consistent with a child’s level of need. Such determinations

flow from specific formulations of medical necessity used in a system of care, and medical necessity per se has not been a focus of this paper. There appears to be merit, however, in refining medical necessity criteria for children’s mental health services. As previously stated, this writer finds the Child and Adolescent Level of Care Utilization System (CALOCUS) to be quite promising as an instrument to assess need. The CALOCUS could be used in association with separately determined medical necessity criteria, assisting in the complex process of service selection and also providing a useful method to track change over time.

A CALL FOR QUALITY, CREATIVITY AND MAKING THE BEST CHOICE

Remarkable changes have occurred in public sector children's mental health over the last 25 years. Twenty-five years ago, the burning issue involved whether or not certain disorders even occurred in children, rather than how to identify and treat them. Systems collaboration was less understood and was uncommon. Treatment tended to follow a "one size fits all" mentality, although some talented clinicians intuitively individualized their treatment. The range of service options was quite narrow, consisting of outpatient therapy in a clinic setting, inpatient treatment, and the beginnings of partial hospital programs. Inpatient beds for children receiving Medical Assistance were typically difficult to find, because many psychiatric facilities limited the number of "MA beds" in favor of beds with higher reimbursements from private insurers.

Residential services were available only for children in protective custody and in juvenile justice. The child with SED could obtain residential treatment only after parents gave up custody of the child to the child welfare system. In addition, there was heavy reliance on state mental hospital units for children. While these facilities benefited some children, in general they represented the antithesis of community-centered treatment. Inpatient stays were prolonged, with little family participation and often little preparation for discharge. Communities tended not to accept responsibility for children in state mental hospitals, and many began careers at a young age in institutional care.

The landscape today is quite different. As a result of the CASSP movement, there is greater recognition of the needs of children and greater resolve to address these needs. The public sector service array has grown substantially, and now these children have many more service options than those with private insurance. State mental hospitals for children have closed and are now a historical footnote, although at times communities still struggle to provide care for those children who in the past would have received treatment in a state hospital setting. CASSP Principles have emerged nationally and in Pennsylvania, gaining a broad consensus here among a range of stakeholders and creating an ethical framework and set of ground rules for service provision. This culminated in 2002 with the release by eight statewide program offices of the Bulletin "Performance Expectations and Recommended Guidelines for the County Child and Adolescent Service System Program (CASSP)," which identifies how CASSP Principles can be implemented by multiple systems at the county level.

Current areas of consensus about children's mental health treatment may at times be taken for granted, but in fact represent a profound change from many of the concepts and practices of the not-so-distant past. Examples of the current consensus include, but are not limited to, the following:

- Mental health treatment needs to be individualized to the unique needs of each child, building on strengths and incorporating relevant cultural elements, natural supports, and community integration.
- Treatment providers need to collaborate with and empower the family, the child's most important support system.
- Treatment needs to enable the child with SED to remain in the community, whenever possible.
- Treatment needs to address not just symptoms and behaviors of concern but also the child's age-appropriate psychosocial development.
- Outcomes in need of systematic tracking include not only symptom amelioration and behavioral improvement but the functional adaptation and developmental progression of the child, and also the level of child and family satisfaction.

With the availability of a broader services array, new challenges arise – in particular, issues of both quality and creativity.

Quality

A service is of benefit only if it is a quality service. CASSP Principles identify quality in terms of specific process and experiential variables, which include family participation, the provision of respect, collaboration and multi-system involvement, attention to community and culture, etc. In addition, quality issues underlie every aspect of the substantive helping process, including the following:

- the comprehensiveness of written reports;
- the integrity, commitment and functioning of the interagency service planning team and the treatment team;
- the qualifications, training, and supervision of specific mental health professionals and support staff;
- the adequacy of the service selection process;
- the individualization of various services and

intervention approaches, including use of psychotropic medication where clinically indicated, and the active participation of both child and family in treatment;

- the degree of coordination, sharing of information, and complementarity among involved clinical staff and with community support persons;
- the integration of mental health with other systems, including those that address physical health, education, vocational training, substance abuse, mental retardation, child protection, juvenile justice, and other systems, as applicable;
- the adequacy of treatment monitoring;
- specific clinical outcomes, based on symptom reduction, behavioral improvement, improved psychosocial functioning, global assessment, and client satisfaction;
- attention to service tapering and discharge, as appropriate.

The attainment of quality requires systematic tracking efforts by agencies, managed care, counties, state government, and other entities, so that a range of variables is monitored at different levels. Consistent with Pennsylvania's service system philosophy, it is essential that families participate in quality management and improvement efforts, including prioritizing areas to be tracked. Beyond the internal tracking of quality, there is ample opportunity for well-designed, externally based research on clinical outcomes and other system variables by universities, foundations, and think tanks.

Quality, it must be appreciated, does not come without cost. Without the provision of adequate time for comprehensive evaluations and the possibility of extended evaluations, critical front-end information will likely be limited, reinforcing a process in which services are "thrown at problems" rather than carefully matched to the well understood needs of children and families. Unless, consistent with a system of care philosophy that upholds collaboration and seamlessness, involved professionals and paraprofessionals are paid to attend team meetings and to exchange information with each other, coordinated team responses and cohesion in treatment will likely be lacking. Services will likely fall short and staff turnover remain high, unless adequate resources are allocated by agencies for the training and supervision of direct care staff.

It is also important to note that fragmented services, by missing the mark, are inherently costly. Does it make sense to spend vast amount of scarce resources on the least trained component of the children's service system, or do

we need to recognize that quality requires leadership, at many levels, from those with the greatest clinical training and experience? If we determine that the system needs the more active involvement, for example, of child and adolescent psychiatrists, how can we make the system welcoming to these individuals, enabling them to offer quality service and not feel marginalized?

Achieving quality also involves making some difficult choices. A service system cannot be everything to everyone. Experience to date suggests that Pennsylvania needs to develop priorities as to how to use scarce resources. While some degree of flexibility is important, there should also be greater clarity regarding what levels of need correspond to what levels of resources and services. Such determinations are both clinically and ethically based, so it is important that resolution be achieved through a highly inclusive process involving a broad range of stakeholders. This process is not without precedent in Pennsylvania. One significant example involved the crafting, in 1995, of consensus language for Pennsylvania's CASSP Principles. Another involved the stakeholder-driven decision one year later to carve out mental health services from physical health, when mandatory managed care began in 1997.

Creativity

Creativity is the foundation of truly individualized care. Creativity can occur at many levels. The psychiatrist or psychologist sets the stage by inquiring about strengths and natural supports and by conveying detailed information about the whole child within his or her life contexts. The interagency service planning team promotes creativity by ensuring that the right individuals are invited to (and assisted in attending, when necessary) the meeting, and by creating a unique experience for child and family. Treatment plans are creative when they identify the helping roles of non-professionals (not just the professionals), address the child in multiple life domains, and make use of services developed *ad hoc*, without invariable reliance on MT, BSC, and TSS bundled at a stock intensity. In order to cultivate creativity, regulations need to balance the need for uniform standards with opportunities for practitioner and agency initiative.

At the services level, many questions arise that require creative analysis and creative problem solving. These include fundamental issues, such as the following:

- How can we ensure quality?
- How can we improve access?
- How can we determine if an apparent service

shortage is due to insufficient capacity or inappropriate use of that service?

- When service capacity is limited, how can we develop partnerships to fill the gap?
- How can we promote new services, especially community-based alternatives to institutional care, so that communities can reach out more often to support child and family?
- How can we more fully achieve blended funding and develop an equitable, collaborative process to address the human service needs of the child, whether or not mental health is the primary system?
- How can we more effectively achieve flexible funding, so that a YMCA membership is not more difficult to obtain than TSS, and respite becomes more readily available to support families committed to maintaining their child in the home and community?
- How can we overcome current regulatory and funding barriers, so that the real needs of children and families can be more realistically met?
- How can we become creative about prevention, and in fact demonstrate its cost-effectiveness?

There is also need for creativity at the clinical level. For example, creativity can be promoted by the use of a positive envisioning process, which can be used during evaluations, treatment sessions, and especially team meetings (see Hodas, 2000). While information about the present and past is important, it is through consideration of a desired future that demoralization gives way to a sense of purpose and change can be jump-started. Envisioning involves asking each family member to identify what the child and family experience will be like, once improvements occur at some identified point in the future. By using an imaginative process to lead the child, family, and team towards the identification of positive future outcomes, envisioning can also guide the team in creating a practical plan to move child and family closer to the vision.

There is also need for creativity and vision in determining how a child can best move through the service system. This requires attention not just to the immediate level of care service being used or requested, but also consideration of how to direct the flow of services, transition the child from one level of care to another, and identify and sustain the use of natural supports, thereby embedding the child more firmly in the community. Movement of a child through the system is promoted when each team member recognizes that there is *one* service system with different parts, all necessarily inter-dependent, not just the service or level of care being provided by that

individual. Only by working together and presuming the good intentions and competence of others can providers truly assist, and then let go of, a child. Movement of a child through the service system is also promoted by a collective recognition that the ultimate goal of help-giving involves enabling the child and family to live as typical a life as possible. This means that self-sufficiency is not just a code word for saving money but a valued outcome that helps child and family to experience purpose, pride, and satisfaction.

The foregoing discussion suggests that the children's service system could usefully direct its attention to the concept of "resiliency, a term applied to children that relates to the child's survival, competence, sense of purpose, and attainment of personal satisfaction, despite the presence of significant challenges and obstacles (Lutar & Zigler, 1991; Waller, 2001). Given the rapid developmental changes and opportunities experienced by children and adolescents and the possibility of their overcoming serious emotional disturbance (SED), families and family advocates prefer "resiliency" rather than the term "recovery," which is applied to adults with substance abuse disorders and serious and persistent mental illness. ["Recovery," however, is an important empowerment concept that should also be understood (Deegan, 1988; Mead & Copeland, 2000), especially in relation to youth transitioning into the adult service system.] Fortunately, resiliency is not solely a biological or constitutional endowment limited to a select group of children, but rather a quality that can be promoted by identifying specific risk and protective factors for the child, and then minimizing the former and maximizing the latter (Rutter, 1987; Pina & VanDenBerg, 1999; Osher, et al., 1999). In effect, then, the concept of resiliency establishes certain responsibilities for professionals working with children and does not apply only to children and their families.

Making the Best Choice, and A Mnemonic to Promote Positive Treatment

The focus of this paper has been on service selection in children's mental health. However, making the best choice in service selection needs to be viewed within the larger context of the entire treatment process, which extends beyond service selection to include service implementation, monitoring, tapering, and discharge. This in turn raises the question of how to guide providers, families, and their teams to produce meaningful change.

One method involves highlighting the key elements that support and facilitate the change process. We already recognize that conscientious fidelity to CASSP Principles

promotes positive change, but CASSP Principles identify ethical more than strategic guidelines. So it would be helpful to identify those elements that, in combination, are critical ingredients in a process for creating change. We can begin with the need for *respect*, since there can be no change, nor even meaningful efforts to provide treatment, when mutual respect is absent. Next, we need to add *hope*, given our recognition that those who seek professional mental health services are faced with demoralization and lack of hope that is as potent as any recalcitrant symptom or behavior (see Frank, 1971). Next comes the need to identify and capitalize on *supports*. Broadly conceived, supports include both the strengths and capacities of child and family and the externally based resources and supports available in the family's larger community. (Franz refers to this combination of individual, family, and community resources as "intrinsic supports.") (Franz, 1994). Now, within a context of respectful, hopeful relationships, the recognition and use of supports, and with an awareness of specific child and family needs requiring attention, there is need to identify the most appropriate professional *services* to assist child and family. Finally, there is need for a *plan* to use the chosen services in a clinically sound, goal directed way. These identified elements, in combination, constitute the basis for meaningful mental health treatment. Each is relevant, separately and in combination, not just at the start of treatment but throughout the entire process, and therefore should be revisited and reviewed on an ongoing basis.

A second way to help others promote meaningful change involves highlighting the temporal dimension of the change process, when effectively undertaken. Change becomes meaningful when it is self-sustaining, maintaining itself over long periods of time, following the departure of the professional change agents. The presumption here is that the family will continue to face challenges, crises, and occasionally the partial re-emergence of symptoms. At the same time, however, the family will also have developed the organizational capacity, specific skills, and facilitative community supports to address such circumstances when they occur, maintaining overall positive functioning and regulation. When needed, refueling through professional services can occur, but the family will be self-sufficient enough to sustain ongoing functioning without the indefinite maintenance of services. When a family achieves the capacity to maintain itself over time without the continued presence of professionals and there is more than just the temporary removal of specific symptoms or behaviors as a result of strengthened family problem solving, we refer to the process as second order change (Watzlawick, et al, 1974; Hoffman, 1981). Second order change constitutes an important goal for children's mental

health and mental health treatment in general.

Consistent with the effort to promote a cohesive, integrated treatment process, a mnemonic is now offered to assist thinking about mental health treatment and the change process. To be sure, a mnemonic does not substitute for a reflective, deliberative process, but it can help trigger such a process by identifying important dimensions for consideration. The mnemonic offered here—**RHSSP**—operates on both of the previously identified levels related to the attainment of meaningful change. First, constructed one way, the mnemonic serves as a reminder of critical building blocks for positive outcomes. Second, the mnemonic, constructed differently, reminds us that the ultimate goal of treatment involves enhanced child and family self-sufficiency.

At the first level, *RHSSP* identifies the components of a methodology that sequentially and in combination leads to positive treatment outcomes:

- R: respect**
- H: hope**
- S: supports**
- S: services**
- P: plan**

As discussed, effective treatment starts with *respect*, uses the therapeutic alliance to restore *hope*, identifies first natural *supports* and then necessary professional *services*, and finally develops a coordinated *plan* to deploy the services and supports in a focused, constructive way. Once the process gets started, it becomes circular and self-reinforcing rather than linear.

At the second identified level, the mnemonic offers a reminder of the ultimate goal of treatment, that of self-sustaining change, and can be read as follows:

Real Help Supports Systems Permanently

Meaningful mental health treatment, while attentive to specific symptoms and behaviors of concern, also has a broader agenda. This includes supporting positive relationships among family members and the family organization as a whole, promoting the child's developmental progression, and helping the family develop realistic mutual expectations and effective methods of independent problem solving. The promotion of family self-sufficiency requires ongoing efforts throughout treatment — through attention to the least restrictive/least intrusive service principle, an ongoing commitment to help the child by working with parents and other essential family members, an ongoing focus on strengths and

progress, and a carefully orchestrated plan for service tapering, discharge, and community integration.

Conclusion

Pennsylvania has already achieved distinction in many areas involving children's mental health. Leadership in statewide government extends back many years, and over the past ten years in particular, the Commonwealth has provided generous support for children's services. Leadership in parent advocacy in Pennsylvania has a long and proud history, serving as an early progenitor of the national movement. Groundbreaking work occurred in Pennsylvania in the area of cultural competence. Strong leadership exists also at the regional and county levels and at the provider level. These strengths were major considerations in the decision to organize statewide, managed behavioral health care under HealthChoices with a right of first opportunity being given to the county. Since its initial implementation in 1997, HealthChoices is proving itself to be a system uniquely well suited to Pennsylvania, blending the strength of county governance and children's mental health and substance abuse values with individualized administrative structures based on local preference. It must be recognized that there is a marked difference between addressing the needs of a limited population of children through a pilot project or foundation grant, on the one hand, and scaling up on a statewide basis, on the other. Yet this is precisely what Pennsylvania has been doing, as other states watch and learn from our experiences.

Our system is not without its limitations, however. Service-specific limitations have been identified earlier, as part of the overall discussion of the array of children's services. The need for facilitative regulations and funding patterns has also been identified, in order to promote genuine collaboration and service responses more closely tied to actual child and family need. Other significant

challenges involve the need for more consistently favorable clinical outcomes for children and their families, and for more systematic tracking of clinical outcomes throughout treatment.

Our recognition of progress made and of unfinished business can inform our future efforts. As we progress, we are well advised to remember that, just as services are of limited benefit without meaningful treatment, so treatment is of limited benefit when it targets symptoms and behaviors without regard for the overall meaning and quality of life of the individual. Thus, we should recall, and rededicate ourselves to, the Pennsylvania Vision Statement developed by OMHSAS under the leadership of Charles Curie, Pennsylvania's Former Deputy Secretary for Mental Health and Substance Abuse Services, now Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the federal Department of Health and Human Services. This Statement articulates the following, still relevant vision:

Every person with serious mental illness and/or addictive disease, and every child and adolescent who abuses substances and/or has a serious emotional disturbance will have the opportunity for growth, recovery, and inclusion in their community, have access to services and supports of their choice, and enjoy a quality of life that includes families and friends.

Meaningful change requires a vision, consensus, and unrelenting effort to see it through. In Pennsylvania, we can build on our past and present while pondering new possibilities. Recognition of both our achievements and our "unfinished business" can provide an impetus to further change. We must summon courage as a community, grounded by CASSP Principles and guided by families, to support and improve the mental health system for our children.

Gordon R. Hodas, M.D. has served as a child psychiatric consultant for the Office of Mental Health and Substance Abuse Services since 1992 and as statewide child psychiatric consultant since 1994. Based in Philadelphia, PA, he is also associate medical director for Wordsworth Human Services and is a senior supervisor for the Philadelphia Child and Family Therapy Training Center. Dr. Hodas is a Fellow of the American Psychiatric Association, and a member of many additional professional organizations, including: the American Academy of Child and Adolescent Psychiatry, the Regional Council of Child and Adolescent Psychiatry, the American Association of Community Psychiatrists, Physicians for Social Responsibility, the American Family Therapy Academy, the American Association of Marriage and Family Therapists, and the American Orthopsychiatric Association. Within the American Academy of Child and Adolescent Psychiatry, Dr. Hodas is a member of the Systems of Care Workgroup and the Family Workgroup. Dr. Hodas is currently awaiting promotion to Clinical Professor in the Department of Psychiatry at the University of Pennsylvania School of Medicine.

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APPENDIX A

CORE PRINCIPLES

Child and Adolescent Service System Program (CASSP)

Pennsylvania's Child and Adolescent Service System Program (CASSP) is based on a well-defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. These principles, variously expressed since the beginning of CASSP, can be summarized in six core statements. When services are developed and delivered according to the following principles, it is expected that they will operate simultaneously and not in isolation from each other.

1. Child-centered

Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

2. Family-focused

Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

3. Community-based

Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

4. Multi-system

Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

5. Culturally competent

Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

6. Least restrictive/least intrusive

Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

Adopted May 15, 1995

State CASSP Advisory Committee to the Office of Mental Health and Substance Abuse Services

APPENDIX B

TABLE OF MENTAL HEALTH CARE
FOR CHILDREN AND ADOLESCENTS

Also available on the web at <http://www.dpw.state.pa.us/Omhsas/CrossSys/omhcsmhc.pdf>

APPENDIX C

SELECTED REGULATIONS, MEDICAL ASSISTANCE AND MENTAL HEALTH BULLETINS, AND OTHER RELEVANT DOCUMENTS

Number	Effective Date	Subject
	1989	Omnibus Budget Reconciliation Act of 1989 (amendments to the Early Periodic Screening, Diagnosis and Treatment provisions of Medicaid)
Title 55. Public Welfare. Chapter 5100	Latest edition, August 12, 2000	Mental Health Procedures
RFP No. 03-02	Issued 2002	HealthChoices Northeast Behavioral Health Request for Proposals (available on the web at http://www.dpw.state.pa.us/omap/rfp/nebh/nebh.asp). The RFP contains the Appendix T on medical necessity referred to in this paper, along with other useful documents governing children's mental health services.
01-93-04	January 1, 1993	Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age (OMAP)
1239-94-01	May 1, 1994	Medical Assistance Case Management Services for Recipients Under the Age of 21 (OMAP)
50-94-01	January 11, 1994	Outpatient Psychiatric Services for Children Under 21 Years of Age (OMAP)
1157-95-00	September 8, 1995	Mental Health Services Provided in a Non-JCAHO Accredited Residential Facility for Children Under 21 Years of Age (OMAP)
1165-95-01	September 8, 1995	Update: JCAHO-Accredited RTF Services (OMAP)
17-97-03	May 28, 1997	Diagnostic and Psychological Evaluations (OMAP)
50-97-05	September 17, 1997	Change in Procedure for Requesting and Billing Therapeutic Staff Support (TSS) Services (OMAP)
01-98-10	July 1, 1998	Change in Billing Procedure for Behavioral Health Rehabilitation Services (OMAP)
01-98-20	December 31, 1998	Accessing Outpatient Wraparound Mental Health Services Not Currently Included in the Medical Assistance Program Fee Schedule for Eligible Children Under 21 Years of Age (OMAP)
50-98-04	December 31, 1998	Procedure for Requesting Prior Authorization of Medical Assistance Case Management Services for Recipients Under the Age of 21 (OMAP)
Title 55. Public Welfare, Chapter 3800	November 20, 1999	Child Residential and Day Treatment Facilities

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Number	Effective Date	Subject
17-99-02	December 3, 1999	Procedures for Licensed, Enrolled Mental Retardation Providers to Access and Submit Claims for Outpatient Behavioral Health Services for Individuals Under 21 Years of Age
OMHSAS-00-04	October 4, 2000	The Roles and Responsibilities of County Mental Health/Mental Retardation Programs in the Development of a Child's Individual Education Program (OMHAS)
41-00-01	March 1, 2001	Prior Authorization of Therapeutic Staff Support (OMAP)
01-01-04	April 26, 2001	Behavioral Specialist Consultant and Mobile Therapist (OMAP)
OMHSAS-01-04	June 8, 2001	Age of Consent for Voluntary Outpatient Mental Health Treatment (OMHSAS)
01-01-05	July 1, 2001	Revisions to Policies and Procedures Relating to Mobile Therapy, Behavioral Specialist Consultant and Therapeutic Staff Support Services (OMAP)
01-01-06	July 1, 2001	Revisions to Prior Authorization of Therapeutic Staff Support (TSS) Services (OMAP)
01-01-07	July 1, 2001	Addition of Behavioral Health Rehabilitation Services to the Medical Assistance (MA) Program Fee Schedule (OMAP)
53-01-01	July 23, 2001	The Use of Seclusion and Restraint in Residential Treatment Facilities (RTFs) (OMAP)
01-02-01	January 1, 2002	Revision to the Early Periodic, Screening, Diagnosis and Treatment (EPSDT) Program (OMAP)
OMHSAS-02-01	April 8, 2002	The Use of Seclusion and Restraint in Mental Health Facilities and Programs (OMHSAS)
OMHSAS-02-02	June 6, 2002	Performance Expectations and Recommended Guidelines for the County Child and Adolescent Service System Program (CASSP) (OMHSAS)
50-02-02	October 1, 2002	Reminder to Providers Who Prescribe Behavioral Health Rehabilitation Services of Documentation Requirements (OMAP)
	2002	Pennsylvania Youth Suicide Prevention Plan (available on the web at http://www.dpw.state.pa.us/Omhsas/omhyspp.asp)

How to obtain copies of bulletins:

Office of Mental Health and Substance Abuse Services Bulletins:

<http://www.dpw.state.pa.us/omhsas/omhbulletins.asp> (link to OMHSAS bulletin web page)

Office of Medical Assistance Programs Bulletins:

<http://www.dpw.state.pa.us/omap/provinf/mabull/omapbullmain.asp> (link to OMAP bulletin web page)

About the Institute

The PA CASSP Training and Technical Assistance Institute addresses the human resource development needs in clinical best practice for serving children and adolescents with mental health needs and their families. As the training arm for children's mental health services of the state Office of Mental Health and Substance Abuse Services, the Institute's programs include the following:

- Competency-based training that integrates OMHSAS policies with clinical best practice
- Technical assistance to meet the individuals needs of agencies and clinicians
- The Children's Interagency Conference
- Publications and resources
- Research and academic outreach

The Institute adheres to the six core principles of Pennsylvania's Child and Adolescent Service System Program (CASSP) and applies them to all programs and activities. Services delivered according CASSP principles are:

- Child-centered
- Family-focused
- Community-based
- Multi-system
- Culturally competent
- Least restrictive/least intrusive

For additional information about the Institute, contact (717) 232-3125, hsb5@psu.edu, or <http://pacassp.psych.psu.edu>