REPORT OF THE CHILD AND ADOLESCENT PANEL FOR THE MENTAL HEALTH MANAGED CARE AND WORKFORCE TRAINING PROJECT

PREPARED BY SYBIL K. GOLDMAN, M.S.W., AND MARISA DE LA CRUZ IRVINE, M.P.P., OF THE GEORGETOWN UNIVERSITY CHILD DEVELOPMENT CENTER, NATIONAL TECHNICAL ASSISTANCE CENTER FOR CHILDREN'S MENTAL HEALTH

FOR THE CENTER FOR MENTAL HEALTH SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, AND THE CENTER FOR MENTAL HEALTH POLICY AND SERVICES RESEARCH AT THE UNIVERSITY OF PENNSYLVANIA MEDICAL CENTER

FEBRUARY 1997

ACKNOWLEDGMENTS

The development of this report would not have been possible without the extensive and thoughtful input of the Child and Adolescent Panel members, all extremely busy individuals, who reviewed, in many cases, lengthy materials in a relatively short time frame. Their insightful comments on the first draft enriched the content of the report. We are most appreciative of their willingness to participate in this undertaking, their expertise, and their valuable contribution to this process and this report.

We also want to acknowledge and thank the agencies, organizations, and institutions that willingly sent their materials and documents at no cost for inclusion in this review. Many managed care organizations were very generous in submitting materials, which to date have not been available for public review.

We were very fortunate this summer to have the able assistance of Amy Levin who provided enormous staff support to this project and kept it on track. We are grateful to Amy for all her help.

And, thanks are due to Susan Williams of the Georgetown University Child Development Center staff for her assistance in the production of this report.

TABLE OF CONTENTS

REPORT OF THE CHILD AND ADOLESCENT PANEL FOR THE MANAGED CARE INITIATIVE

I. INTRODUCTION AND OVERVIEW

The Center for Mental Health Services, in conjunction with the Center for Mental Health Policy and Services Research at the University of Pennsylvania, has undertaken an initiative to identify core competencies and training materials for professionals providing mental health services in this era of managed care. The first phase of this project has focused on identifying and evaluating materials in a number of categories -- standards, clinical protocols and practice guidelines, level of care criteria, core competencies, and training curricula. This initial identification and assessment of the current "state-of-the-art" is intended to serve as the basis for determining core provider competencies, identifying existing relevant training and educational materials, and developing additional materials to prepare professionals to practice effectively within the context of managed care. Eight panels addressing specific target population groups and their service needs have been established to conduct this review and analysis. These panels include Adults, Children and Adolescents, Older Adults, African Americans, Latinos, Native Americans, Asian Americans, and Persons with Co-Occurring Disorders. This document is the report of the Child and Adolescent Panel as a part of this larger initiative.

The Child and Adolescent Panel (see Appendix A) includes a distinguished group of individuals representing expertise in a number of critical arenas for a child and adolescent population that has mental, emotional, and behavioral problems. The panel includes representation from key disciplines serving this population -- social work, child psychiatry, psychology, nursing, and counseling -- representation from public and private sector mental health, child welfare, health, and education agencies, from families, managed care organizations, the research field, higher education, policy, and practice.

Panel members were asked to identify materials in the previously specified categories and to review specific materials describing their strengths in delivering appropriate and quality services to children and adolescents, in training and enhancing workforce competencies, in improving accountability, and in achieving good outcomes. Panel members were also asked to note limitations of the material related to appropriate service delivery and treatment, accountability, workforce competencies, and training. Where possible, panel members reviewed materials related to their expertise. This report represents a compendium of those materials and analyses with an overall assessment of the current "state-of-the-art" and what is needed to advance the field, particularly given the expansion of managed care technology to mental health services for children and adolescents in both the public and private sectors.

In determining parameters for this project, certain assumptions were made. The Panel did not review the universe of literature on best practice or research on child and adolescent service delivery and treatment interventions. Rather, as indicated, the focus of this review was limited primarily to standards, clinical and/or practice guidelines, level of care criteria, core competencies for multiple

disciplines and practice, and training curricula. The rationale for that decision is described in Section II, which provides background information on progress made in the development of knowledge on child and adolescent mental health and effective service delivery for this population. Section III provides a summary of findings from this review of materials; Section IV delineates challenges and recommendations for action; and Section V provides a description of the content of the materials with strengths and gaps noted.

II. BACKGROUND ON SERVICE DELIVERY FOR CHILDREN AND ADOLESCENTS WITH MENTAL HEALTH PROBLEMS, AND THEIR FAMILIES, AND THE IMPLICATIONS OF MANAGED CARE

Progress in Knowledge Development on Child and Adolescent Mental Health and Effective Service Delivery

In the last 15 years, there has been increasing attention paid to the mental health needs of children, adolescents, and their families and service delivery to this population. While studies and commission reports in previous decades (Joint Commission on the Mental Health of Children, 1969 and the President's Commission on Mental Health, 1978) documented the mental health needs of children and adolescents as well as problems and inadequacies in the service delivery system, it was not until the publication in 1982 of Jane Knitzer's report, *Unclaimed Children*, that a more concerted national effort began to address these issues.

In 1984, in response to concerns of families, advocates, service providers, administrators, and policy makers, Congress initiated the Child and Adolescent Service System Program (CASSP), initially administered by the National Institute of Mental Health (NIMH) and then under the jurisdiction of the Center for Mental Health Services (CMHS) following a federal reorganization. The goals of CASSP were directed at the federal, state, and community levels to focus on the needs of children with mental health problems and to reform service delivery for children and adolescents, most specifically those with serious emotional disturbances, but also those at risk. From the CASSP initiative, a set of values and principles evolved, articulated in Stroul and Friedman (1986/1994), that defines a system of care for this population of children. (See Exhibit 1.) The values and principles that provide the foundation of a system of care have been broadly embraced by multiple constituencies and multiple service systems as the standard for service delivery for children and adolescents with a range of mental, behavioral, and emotional disorders.

From 1982 to 1996, there has been an increased understanding of the mental health needs of children and adolescents and how to deliver services to this population and their families, and this knowledge

EXHIBIT 1

VALUES AND PRINCIPLES FOR THE SYSTEM OF CARE

(From Stroul and Friedman, 1986/1994, A *System of Care for Children and Youth with Severe Emotional Disturbances)*

CORE VALUES

1. The system of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community-based, with the locus of services as well as management and decision making responsibility resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

GUIDING PRINCIPLES

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

has contributed to an expanding literature. In the early 1980's, there was a paucity of information and publications on children and adolescents with mental health problems. Since that time, there has been a dramatic increase in publications, articles, and research providing a better understanding of the mental health needs of children and addressing the many dimensions that are involved in service delivery to this population. The body of literature for children and adolescents expands the knowledge base on the population itself -- on the mental disorders affecting children and adolescents, the etiology, risk and protective factors, incidence, and prevalence. Most dramatic, however, has been the rapidly growing literature expanding the knowledge base on the complex dimensions of service organization and delivery for children including the following: family involvement, cultural competence, prevention, early identification and intervention, access, assessment and diagnosis, treatment planning, treatment interventions, treatment and service settings, integration of mental health and other child-serving systems, system of care development, effectiveness of services and treatment interventions, outcomes and accountability, human resource development and training, and financing. (See Appendix B for Selected References and Bibliography for this literature.)

It is important to emphasize that while there has been much progress made in the knowledge base related to children and adolescents with mental health problems, there is still much more to be known and documented in multiple dimensions (for example, on incidence and prevalence, service and treatment effectiveness and what works best with different youth and families, valid and reliable measures to determine effectiveness, outcomes, and costs). Further, while there is broad consensus about the principles and values that define best practice and provide a foundation for service delivery to this population, there are some differing views on implementation strategies and approaches depending upon the perspective of the stakeholder or constituency group (for example, on the role of medications, the role of various treatment settings, and the role of a range of community-based alternative providers). Reliable data are often lacking to substantiate particular treatment approaches. Major strides have been made in strengthening the research base with greater investments and increases in research activities. But in the children's field, research and evaluation is still in a developmental phase (OTA, 1986; IOM, 1989; Burns & Friedman, 1990; Bickman, 1993; Kutash & Rivera, 1996). There are also concerns about preparing and building an adequate workforce in child mental health (Pires, 1992). Both the capacity and capability of the workforce specializing in child and adolescent mental health and service delivery need to be enhanced. Additionally, training, both pre-service and in-service, need to reflect the current knowledge base. Higher education programs, which often are leaders in defining core workforce competencies, have not kept pace with the changing and emerging practices in the field (Kravitz, 1991).

The purpose of this Panel was not to conduct a comprehensive review of this literature or the various perspectives on different approaches, rather it was to determine if the principles that have broad acceptance and the learnings derived from this body of knowledge have been incorporated and reflected in the standards, practice guidelines, core competencies, and training curricula currently being developed and/or used by different constituencies, especially as managed care approaches are implemented.

Growth of Managed Care and its Impact on Practice in Child and Adolescent Mental Health

As for the population as a whole, managed care approaches, technology, and arrangements are having a profound impact on the delivery of mental health services to children and their families -- whether they receive services in the private sector reimbursed through private health insurance or whether they are served in the public sector through publicly-funded and reimbursed services. In a study conducted of state initiatives, 44 states have implemented, or are in the process of implementing, managed care practices in Medicaid for children in that state and 40 states have, or are in the process of implementing, managed care in behavioral health care for children (Pires, et al., 1995).

Many children whose families have private insurance are already receiving care that is managed by health maintenance organizations (HMO's) or other similar arrangements. There are many definitions of managed care, but according to Schafer (cited in Stroul, 1995), the simplest, most positive explanation of managed care is that it, "provides children and families the services they need, when they need them, in the right amount, no more, no less." In other words, a managed care system depends on delivering the *right* mix of the *right* services at the *right* time. Two critical elements of managed care technology necessary in achieving this delicate balance involve establishing consistent clinical procedural and practice protocols and developing and maintaining qualified provider networks (Stroul, 1995).

While managed care offers opportunities to develop a more flexible, responsive, and cost-effective service delivery system, there are also real risks and threats to the progress that has been made in improving service delivery to a vulnerable population of children and families (Stroul, 1995). Standards, clinical and practice guidelines that implement core values and principles, outcome measures, core competencies, and accountability procedures that reflect best practices are essential to safeguard that the population served through managed care is receiving appropriate and quality services delivered by appropriate and qualified personnel. These vehicles are a means of assuring that cost is not the only driving force, that a vulnerable population is not under- or inappropriately served, and that what has been learned is being utilized.

Currently, there is an explosion of activity -- with states developing contracts with managed care companies to serve a targeted population; with managed care companies developing protocols for provider networks; with professional groups developing practice guidelines for their members to function effectively and competitively in this environment; and with consumer groups and standard-setting bodies establishing values and benchmarks for guiding and evaluating service delivery and ensuring accountability. To date, there has been no review or assessment of this emerging new "literature" that has the potential of profoundly changing how services are delivered.

This review provides an initial examination to determine if these materials are incorporating and addressing the following key concepts that:

- Services are **child- and family-focused** with the needs of the child and family dictating the types and mix of services;

- Services are **community-based** with the locus of service near to where the child and family lives and provided in the least restrictive, most normalized environment that is clinically appropriate for the child;

- Services are **culturally competent** with policies, administrative practices, and treatment interventions responsive to the cultural, racial, and ethnic populations served;

- **Families** are **full participants** in all aspects of planning, service delivery, and treatment;

- Assessment, treatment planning, and services are developmentally appropriate and **individualized**, **based on the unique needs and strengths** of each child and family;

- Children have access to a **comprehensive array of services** that address the child's physical, emotional, social, and educational needs;

- Services are **integrated and linked** between child-serving agencies and programs;

- **Early identification and intervention** are promoted to increase the likelihood of positive outcomes; and

- **Outcomes** to be achieved are delineated and a system for **accountability** built in.

The identification and review of these materials by the Child and Adolescent Panel are a first step in this process to determine at this point in time if the standards, clinical guidelines, core competencies, and training materials that are being developed and utilized are based on the principles and values that have been accepted by the field and on the knowledge developed about best practice over the course of the last 15 years. Managed care technology should be applied to what has been learned about effective service delivery for children and families. And, service providers must have the values, skills, and knowledge to work effectively with children and families.

III. OVERALL ASSESSMENT AND OBSERVATIONS: STRENGTHS AND IDENTIFIED GAPS

The materials obtained and included in this report were identified by Child and Adolescent Panel members, the National Technical Assistance Center for Children's Mental Health at Georgetown University, the Center for Mental Health Services, and the Center for Mental Health Policy and Services Research at the University of Pennsylvania. While the documents in each category are not all inclusive of what has been developed (for example, states other than the ones included have developed care criteria and contract specifications for managed care companies), they provide a representative picture at a point in time of the current "state-of-the-field." It should be noted that managed care companies were generous in making materials available to the Panel, and these practice

guidelines and level of care criteria were included in the review. However, because such materials are proprietary, they are only referenced in the report. The descriptions and individual reviews have not been included.

From this process of identifying and reviewing standards, level of care criteria, practice guidelines, core competencies, and training materials, it is evident that this is a time of dynamic development -- what exists now for each category of material is in an evolutionary state. The fact that many different constituency groups are involved in the development and issuing of such materials is an indication of their importance in defining practice as well as in protecting and balancing the interests and concerns of key stakeholders in the service delivery system whether they are purchasers, consumers, providers, insurers, governing and regulatory bodies, or accrediting bodies. The financing and delivery system for health and mental health is undergoing rapid changes and restructuring, and, as a result, the tools for decision making and accountability are being revised to meet these new demands. There are legitimate concerns that the restructured system be built on what is generally accepted to be best practice. At the same time, there are limitations imposed by the reality that both the knowledge base and technology are still evolving and developing. For example, child and adolescent service delivery systems are moving to outcome indicators, but, in fact, it is often difficult to track and match significant outcomes for a child population to specific interventions.

These tensions, as well as the evolutionary nature of development, are reflected in the body of materials reviewed by the Child and Adolescent Panel. The materials, for the most part, reflect a multiplicity of voices and perspectives focused on particular interests and a fragmented, categorical "system." Furthermore, the review for this report focused on an examination of documents. Panel members emphasized that while it is important to articulate standards, practice guidelines, core competencies, and training curricula to ensure quality service delivery, it is necessary to go beyond a "paper check" to establish what is occurring and if that is making a difference. Accountability is essential 1) to establish if services and practices are consistent with values and principles and 2) if services are producing good outcomes.

Much of what has been identified and developed in each of these categories, especially for accreditation standards and level of care criteria, is adult-focused. If adaptations have been made to address the needs of a child/adolescent population and their families, these modifications are generally minimal. Modifications usually indicate that child and adolescent populations have special or unique needs, most often acknowledging developmental issues and involvement of the family, but there is little to no elaboration on how to adapt treatment. Also, the service components addressed are often not differentiated for children; they are, for the most part, the same as for adults. There is minimal recognition of the role and importance of the multiple agencies and systems that a child who has mental health problems can be involved with -- health, education, mental health, child welfare, substance abuse, and/or juvenile justice. In general, for those materials that have been developed for a child and adolescent population, or include a child and adolescent focus, there is considerable diversity in how they address the unique dimensions of an effective child and adolescent service delivery system and the principles of care delineated in Exhibit 1, on page 3. Overall, the documents relating to standards, core competencies, and training curricula (as opposed to practice guidelines and

level of care criteria) are likely to be more comprehensive in addressing these principles. A brief summary of the findings of the review are described for each of the categories below.

Standards of Care

Standards establish the principles and baseline specifications for service delivery, but it is the actual implementation and operationalization of these standards that ensure effective services and outcomes for children and families. Therefore, to be effective, standards must include benchmarks and processes for accountability to measure whether these specifications are met.

For children and adolescents, there is no definitive document (other than the CASSP System of Care principles previously referenced), endorsed by multiple constituencies, that establishes a set of standards and benchmarks to serve as a report card for measuring and evaluating quality of care. At the federal level, the Center for Mental Health Services has made a major contribution to the literature in the development of the *Consumer-Oriented Mental Health Report Card.* This document delineates indicators under key areas of access, appropriateness, outcomes, and prevention, many of which are relevant for children and their families, but are not specific to this population. A similar effort needs to be undertaken for youth. CMHS has also developed a brochure outlining the *Principles for a System of Managed Care;* however, these principles are broad and, while children are addressed, the intent is more generic.

The Federation of Families for Children's Mental Health and the National Alliance for the Mentally Ill (NAMI) have also made contributions in the materials that each of these consumer-oriented organizations have developed. But, as acknowledged in the respective documents, the material included represents a beginning step to the development of standards for quality care to children and adolescents with mental health problems and their families. The Federation sets forth *Principles for Family Involvement in the Development and Operation of Managed Health and Mental Health Systems for Children and Youth,* but it is not comprehensive in the issues addressed and includes no indicators. NAMI's, *Mental Illness and Managed Care: A Primer for Families and Consumers,* is just as the title states, a primer; it does not provide a set of principles and standards, and it does not specifically address children and adolescents.

The State Mental Health Representatives for Children and Youth's document, *Successful Integration of System of Care Development with Managed Behavioral Healthcare Technologies in Public Children's Mental Health,* referred to as a "work in progress," provides a useful foundation for the development of standards and a report card, but it also is an initial step highlighting the basic issues important in the delivery of mental health services and supports to children, adolescents, and their families. Many states have developed, or are in the process of developing, standards, and several examples are included in this report. However, no product has been identified to date to serve as a model for other states.

Professional groups have been in the forefront of developing standards and codes of ethics to guide professional practice; however, these standards generally reflect the perspective of a particular

professional group and discipline usually for the members of that group rather than for the service delivery system. While professional standards typically advocate respect for the consumer and value the input of consumers and families, the standards are not consumer-driven nor child- and family-focused. They do, however, provide a rich and valuable resource for the development of quality of care standards and core competencies. The professional standards reviewed for this report varied in their attention and adherence to core concepts of service delivery for children and adolescents reflected in the literature and the principles of care delineated in Exhibit 1.

Various accrediting bodies have developed standards for the accreditation of provider organizations that include facilities and agencies that deliver services to children. With the exception of the Council on Accreditation, which accredits organizations, agencies, and programs providing behavioral health care and social services for children and families, these standards minimally address children's issues and are not consumer developed or focused. But, these accrediting bodies can play a critical role in influencing the provider community, so it is important that their standards reflect key concepts of best practice. From this review, few of these concepts are incorporated such as a strengths-based approach to assessment and treatment, collaboration among child-serving agencies, and a comprehensive array of services including services that are less restrictive than hospitalization and more intensive than outpatient.

Clinical Guidelines, Protocols, and Level of Care Criteria

Clinical protocols describe a course of treatment or established practice pattern that provides a guideline for decision making related to assessment and treatment for particular conditions and/or diagnoses; level of care criteria provide guidance for decision making related to different treatment settings and approaches. The documents reviewed by the Child and Adolescent Panel often included some combination of the following: practice guidelines, level of care criteria, medical necessity criteria, quality assurance procedures, and utilization review. These materials primarily have been developed by state governments to guide managed care organizations and providers under contract to the state to provide care for particular populations, by managed care companies to guide the clinical treatment decisions of the providers in their network, and by professional organizations to define established practice patterns based on clinical and services research to guide practitioners. The Child and Adolescent Panel review also included a literature review and summary of practice guidelines, conducted by a consulting firm, to be used as a protocol for the Department of Defense (DoD) and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

While practice guidelines and level of care criteria (that are based on best practice) are important in establishing a consistent protocol for treatment decision making, they are inherently categorical. An individualized approach to treatment planning involves examining the domains of a child and family's life (the home, school, and community), assessing with the family both strengths and needs, and developing a treatment plan based on that assessment. The practice guidelines and level of care criteria reviewed are diagnosis- or service-specific, which actually can hinder a more holistic, flexible approach -- hallmarks of effective service delivery for children.

The panel review found tremendous variety, as well as some overall consistency, in the practice guidelines and level of care criteria developed and currently utilized by these constituencies. The predominance of clinical guidelines and level of care criteria is adult-focused. If children and adolescents are included, the attention is minimal. In general, and especially for the managed care organizations, the guidelines reflect a more medical model approach rather than a holistic, integrated approach addressing the physical, emotional, social, and educational needs of children. This is certainly not surprising given that these clinical guidelines define parameters of care, and the parameters of care focus on medical necessity. For those level of care criteria that address children and adolescents, the services included are usually inpatient, residential treatment, partial hospitalization, and outpatient; not a comprehensive array of community-based services and supports including in-home, respite, crisis options, as well as others. Guidelines, for the most part, address acute rather than extended care. In all these documents, however, there is a certain consistency, for example, in the factors to include in the assessment process or in some of the criteria for treatment decision making (e.g., treatment in the least restrictive environment that is clinically appropriate, hospitalization only in those cases where an individual is in danger to self or to others, etc.). And in many cases, the guidelines emphasize that they only provide a framework; much is left to the judgment and experience of the clinician/professional/individual making the actual decision and determination.

While there is a tremendous range in the scope and degree to which many of the best practice approaches emanating from the system of care principles have been incorporated in practice guidelines, there seems to be a growing recognition of the importance of family involvement articulated in many different ways; not separating a child from the family, if at all possible; broadening the service array; using multidisciplinary teams; developing individualized treatment plans; and, in a very few cases, addressing cultural and linguistic differences.

Many of the guidelines obtained from the managed care organizations do not have a separate section for treating children and adolescents; in some cases, as indicated previously, the unique needs of children are referenced in the guidelines, but the level of care criteria are actually the same as for adults. For some, guidelines are included for certain disorders specific to children and adolescents such as attention deficit hyperactivity disorder and eating disorders. In a number of cases, however, managed care companies have developed specialized guidelines for a child and adolescent population that address at least certain aspects of service delivery and treatment unique for children including a broader array of services, guidelines for involving families, a strengths-based approach, prevention, and early intervention. Guidelines from the managed behavioral health care companies focus on acute care and do not address the extended care needs of a population with severe emotional disturbances.

The state level guidelines included in the review cover a broader array of services including crisis, respite care, in-home, and flexible "wraparound" services. However, with the exception of North Carolina's, they tend to be highly regulatory, emphasizing restrictiveness rather than flexibility.

The only level of care criteria and practice guidelines reviewed that were developed by a professional group were those developed by the American Academy of Child and Adolescent Psychiatry. These

practice guidelines are more comprehensive in their coverage of assessment and treatment issues of major diagnostic categories for children and adolescents including attention deficit hyperactivity disorder, conduct disorder, anxiety disorders, and schizophrenia. Those addressing the latter two disorders are more fully-developed providing useful descriptions of etiology, clinical features, and treatment options supported by references. These practice guidelines reflect a psychiatric perspective but incorporate an understanding of the child in the context of family, school, and community. The level of care criteria are endorsed by a number of organizations and address those settings most "frequently utilized": inpatient hospitalization, residential treatment, acute partial hospitalization, intensive outpatient, and general outpatient treatment. These criteria appear to be more facility-focused than child- and family-centered.

Provider Competencies

Of all the materials reviewed, those related to provider competencies demonstrate the most progress in incorporating values and key elements of best practice for serving children, adolescents, and their families. However, panel members strongly emphasized that these competencies are not being adequately incorporated in higher education training and are not reflected in professional practice. With two notable exceptions, the competencies reviewed tend to focus on particular professions or functional areas such as child welfare or mental health. In this new era, it will be important to acknowledge and incorporate the contribution of providers other than the major professional disciplines and to establish processes for accountability for all providers delivering services to children and families.

In particular, the documents on the core competencies for an interdisciplinary workforce, developed by Trinity College of Vermont's Center for Community Change for the Center for Mental Health Services (in draft version, not for distribution) and by the Pennsylvania CASSP Training and Technical Assistance Institute, make a major contribution in articulating a comprehensive set of core competencies for practitioners working with children with emotional and behavioral problems. The set of core competencies presented by Trinity College was synthesized from the thinking, writing, and practical experience of leading individuals in the field and then refined through a national multi-perspective review process; these competencies have broad applicability for a child and adolescent workforce. For a summary of these competencies, see Exhibit 2, on page 12. Pennsylvania CASSP has developed core competencies related to children, families, and communities that will serve as the foundation for a training program in that state for practitioners working in children's mental health.

The Institute for Human Services has produced a comprehensive set of competencies for promoting family-centered, culturally-relevant, and interdisciplinary child welfare practice and training. This body of work also has the potential to move the field forward if implemented.

EXHIBIT 2

MAJOR CATEGORIES OF SYSTEM OF CARE WORKFORCE COMPETENCIES FOR STAFF SERVING CHILDREN AND YOUTH EXPERIENCING A SERIOUS EMOTIONAL DISTURBANCE AND THEIR FAMILIES

(*System of Care Workforce Competencies* developed by Laurie C. Curtis, M.A., Project Director, Senior Mental Health Consultant, Center for Community Change through Housing and Support, John Burchard, Ph.D., Department of Psychology, University of Vermont, and Michael Curtis, Ed.D., Director of Children, Youth & Family Services, Washington County Mental Health Services, Montpelier, Vermont)

Note: This listing only includes the major headings and sub-headings. More specific competencies may be found in the body of this report.

1. **Demonstrates respect for children and youth experiencing a serious emotional disturbance, their families, community, and culture.**

   A. Uses language and behavior which consistently reflects and perpetuates the dignity of individual children, youth, their family members, their culture and their communities.

   B. Communicates understanding of unique issues facing individual children, youth, their family members, and their communities.

   C. Recognizes and builds upon the strengths and abilities of individual children, youth, their families, communities, and culture.

2. **Demonstrates an ability to build and maintain positive relationships with individual children, youth and their families in their community.**

   A. Operationalizes the principles of unconditional care.

   B. Involves child or youth in service planning and support activities.

   C. Invites family involvement in service planning and support activities.

   D. Provides information as needed.

3. **Works in a cooperative and collaborative manner with all stakeholders (including individual children, youth, family members, colleagues, other agencies, community members) in the design and delivery of individualized service plans.**

   A. Demonstrates basic understanding about diversity of purpose and values among

stakeholders.

B. Demonstrates understanding of the variation in missions and mandates between different child-serving agencies.

C. Promotes coordinated service and support decisions among all treatment team stakeholders.

D. Assists in building positive treatment team relationships.

E. Develops and maintains good relationships with community representatives.

4. **Demonstrates knowledge about human development, serious emotional disturbance, and behavioral disorders.**

A. Demonstrates basic knowledge about human development.

B. Demonstrates basic knowledge about family systems.

C. Demonstrates understanding of stressful life events on children, youth and families.

D. Demonstrates knowledge abut the etiology, characteristics and courses of serious emotional disturbances and behavior disorders.

E. Demonstrates knowledge about psychotropic medications.

5. **Demonstrates knowledge of a variety of approaches to intervention and support for children, youth and their families.**

A. Operationalizes the principles of family-oriented, community-based services.

B. Demonstrates basic communication and supportive counseling skills.

C. Demonstrates understanding of basic principles of behavior and social learning.

D. Demonstrates understanding of a variety of community-based service approaches and best practices.

E. Demonstrates knowledge of best practices in crisis prevention and intervention approaches.

6. **Participates in the design, delivery, and evaluation of individualized services and**

supports.

A. Participates in the assessment of individualized service and support needs of child or youth and family.

B. Participates in the design of individualized service and support plans which match the ideals, needs, strengths and preferences of the child or youth and family.

C. Participates in the delivery of services and supports as outlined in negotiated plans.

D. Assists child or youth, their family, and community in assessing success and satisfaction with service outcomes.

7. **Demonstrates general knowledge about service systems for children and youth experiencing a serious emotional disturbance and their families.**

A. Demonstrates basic knowledge of local and state family support and advocacy resources.

B. Demonstrates basic knowledge of local and state child and youth support and advocacy resources.

C. Demonstrates ability to access wide range of community resources.

D. Demonstrates general knowledge of entitlement and benefit programs.

E. Demonstrates general knowledge of legal system.

F. Demonstrates general knowledge of educational system.

G. Demonstrates ability to secure additional information as needed.

8. **Conducts all activities in a professional manner.**

A. Adheres to recognized ethical standards.

B. Demonstrates knowledge and respect of individual rights.
C. Performs work in a positive manner.

D. Demonstrates ability to take care of one's self as a worker and as a person.

9. **Pursues professional growth and development.**

    A. Seeks out and engages in learning opportunities.

    B. Evaluates work effectiveness through feedback.

    C. Integrates new learning into daily work practices.

The American Academy of Child and Adolescent Psychiatry, the National Association of Social Workers, the American Mental Health Counselors Association, and the National Association of School Psychologists have developed practice guidelines for their professional members and for specific service areas that establish standards as well as the values, skills, and knowledge necessary to ensure competent practice. In many cases, these guidelines reflect the changing delivery system and best practice concepts. However, while they are intended to shape and influence graduate education and in-service training, the Child and Adolescent Panel reviewers commented that these practice guidelines are not being implemented to the degree necessary to achieve an effectively trained and competent workforce.

This delineation of essential competencies represents only one aspect of developing a competent workforce. Inclusion in training, education, and supervision is critical to operationalize these competencies. Success in their application depends on practitioners integrating the values and attitudes, applying the knowledge and skills, and exercising professional judgment. In addition, measures and performance indicators need to be developed and employed to ensure achievement and accountability. These are challenges that need to be addressed.

These materials on provider competencies explicitly set out the values, attitudes, knowledge, and skills to enable child and adolescent service providers and administrators to practice more competently and/or to achieve a more effective service delivery system. However, other materials reviewed in this report also both explicitly or implicitly identify and/or define core competencies for practitioners or for the service delivery system. This information, extracted from all the materials reviewed, is summarized by key stakeholder groups in the tables displayed at the end of Section III, pages 18 to 32.

Outcome Guides and Studies

Because of managed care, increasing attention is being paid to outcomes for children and adolescents. Research efforts have recently been focused on establishing and measuring both individual and system outcomes to determine the effectiveness of treatment, service interventions, and systems of care (Behar, 1992; Bickman, 1993; Stroul, 1993; Stroul, McCormack & Zaro, 1996). Outcomes include those related to individual functioning (e.g., reduction of symptoms and improvement in functioning in the home, school, and community), parent and youth satisfaction, and those outcomes related to systemic issues (e.g., cost reductions, decreases in school drop-out rates, decreases in juvenile detention and recidivism rates, and increased use of less restrictive settings).

State governments, managed care organizations, consumer groups, professional and provider groups, among others, are all currently struggling with determining outcomes that will ensure quality care, are cost effective, and are capable of being measured. To date, there has been no consensus development among key constituencies to determine a set of outcomes for child and adolescent behavioral health that has broad acceptance. (However, the Center for Mental Health Services has convened a technical panel to begin this process. In addition, the Substance Abuse and Mental Health Services Administration has charged an expert panel of the Institute of Medicine to convene an expert

committee to make recommendations related to quality assurance and accreditation in managed behavioral health for adults and children.)

The Child and Adolescent Panel for this Initiative did not conduct a comprehensive review and analysis of outcome studies or outcome measures. Such an analysis would be an important next step in this process and make a significant contribution to the development of practice guidelines and core competencies. The only document reviewed was a guide developed by the Judge Baker Children's Center for evaluating consumer satisfaction with child and adolescent mental health services. The guide acknowledges the lack of a theoretical base for the study of consumer satisfaction, the need for much work to be done quickly, and the inadequacy of current consumer satisfaction instruments.

Training Materials and Curricula

A limited number of curricula were reviewed for this report in part because curriculum documents are very lengthy, and such a review would, by necessity, constitute a separate review unto itself. The curricula reviewed were identified as potentially incorporating the values, principles, and key concepts of best practice in child mental health. Two of the documents reviewed focus on an aspect of service delivery for children and families, one on case management and the other on crisis intervention. While these are both critical components of a service delivery system for children and adolescents, they represent only a piece of the system of care. The curriculum developed for staff of the South Carolina Department of Mental Health is comprehensive and multi-disciplinary and reflects the CASSP principles. From this limited review, it is difficult to provide even a cursory assessment of the "state-of-the-art" or make any meaningful observations.

CORE COMPETENCIES IDENTIFIED OR DEFINED BY FEDERAL GOVERNMENT DOCUMENTS

DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
CMHS, *Principles for System of Managed Care*	✓ Treat individuals with respect and dignity	✓ Support of partnerships, collaboration		

CORE COMPETENCIES IDENTIFIED OR DEFINED BY CONSUMER GROUP DOCUMENTS

CONSUMER GROUP/DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
Federation of Families for Children's Mental Health, *Principles of Family Involvement...*	✓ Family involvement must be institutionalized at all levels of a managed care system.	✓ Belief in the strength and importance of families.	✓ Information about managed care technologies.	
NAMI, *Mental Illness and Managed Care: A Primer for Families and Consumers*	✓ Consumers and families must be involved in the design, development, and evaluation of a reformed system. ✓ A comprehensive array of services must be provided. ✓ Services must be individualized and flexible. ✓ Consumer rights are to be protected.		✓ Staff should be knowledgeable about and involve families. ✓ Staff should be experienced in working with persons with serious mental illness. ✓ Staff should be knowledgeable about the array of available local social services.	

CORE COMPETENCIES IDENTIFIED OR DEFINED BY STATE GOVERNMENT DOCUMENTS

STATE/ DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
Hansen, Anderson, et. al. *Child, Family and Community Core Competencies.* **Pennsylvania** CASSP Training and Technical Assistance Institute	✓ Support collaboration with families ✓ Strength based orientation	✓ Demonstrate the willingness to implement the following skills: ability to foster mutual admiration and respect of children in this age group and ability to decrease family's tendency toward guilt/blame	✓ Demonstrate general knowledge of the emergence of gender preference, teens' awareness of the opposite sex, social functioning of children within an age group, physical and sexual development, emotional functioning	✓ Ability to inquire about sexual behavior ✓ Ability to collaborate with families in developing an optimal service plan ✓ Ability to identify and appreciate the strengths of teens from various culture groups
State of **Delaware**, *Mental Health Services for Children and Adolescents Criteria for Hospitalization*			✓ Risk assessment and levels of care within a continuum of services	
Commonwealth of **Massachusetts**, *Standards, Clinical Criteria, Practice Guidelines*	✓ Emphasis placed on educating and respecting the consumer ✓ Value of consumer and family involvement ✓ Commitment to understanding and responding to human diversity	✓ Attitudes for clinicians Ex: Ensure that consumers are treated with dignity and respect; have the opportunity for self-determination and freedom of choice to their fullest capacity; have the opportunity to enhance their self-esteem through positive accomplishment; etc.	✓ Knowledge about and ability to use a variety of therapeutic interventions	✓ Skills and practices for clinicians Ex: Residents/interns understand the cultural context in which the individual is treated. Residents/interns demonstrate competency in the use of a variety of cognitive, family, group, and behavior therapies.

STATE/ DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
21 State of **New Mexico**, *Certification Standards for Children and Adolescent Mental Health Services*		✓ Behavioral management specialist: attitude to work with families in a supportive, non-judgmental manner in the home/community environment.	✓ Specifies qualifications and experiences for various providers. Ex: child care worker's training in family systems, child development, basic communication and problem solving skills, etc.	✓ Calls for training to be provided to treatment foster parents, behavioral specialist child worker, not skills necessary to fill these roles.
22 State of **North Carolina**, *Cardinal Child/ Adolescent Mental Health Service System Criteria...*	✓ While there is no introductory material that explains the *Criteria*'s value base, there is implicit value in the concept of a better need to understand how need relates to level of care. In addition, there is implicit value in not viewing all "intermediate" services as the same, and in the development of guides for each service along the mental health continuum.		✓ This document offers an early attempt at better defining how various service modalities can and should be utilized within a system of care.	
State of **North Carolina**, *Levels of Care for Psychiatric and Substance Abuse Diagnosis*	✓ Strength-oriented models ✓ Rehabilitation focus ✓ Building on family strengths and resources			

GENERAL CORE COMPETENCIES IDENTIFIED FOR PROVIDERS

DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
Curtis, Burchard, and Curtis, *System of Care Workforce Competencies for Staff Serving Children and Youth Experiencing a Serious Emotional Disturbance and their Families*	✓ Key values include a strong focus of individual strengths, individualized service planning, and family participation in all levels of system operation. ✓ Focus on understanding cultural and community aspects of an individual's care.		✓ Comprehensive knowledge base ✓ Knowledge about individualized strengths and service approaches as vital to the system of care.	✓ Comprehensive listing of skills ✓ Assumption is that all of the various skills will be available to individuals and families served by the system of care, and that everyone should have some level of understanding of those skills and their value and use. (See Exhibit 2)

CORE COMPETENCIES IDENTIFIED BY AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY (AACAP) DOCUMENTS

DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
AACAP's, *Guidelines for Training Towards Community-Based Systems of Care for Children with Serious Emotional Disturbances*	✓ Child-centered, family-oriented ✓ Least restrictive level of care ✓ Community-based ✓ Culturally competent ✓ Interdisciplinary ✓ Public-Private integration	✓ Well-grounded identity as a child and adolescent psychiatrist ✓ Flexibility and resourcefulness ✓ Willingness to adapt interventions to unique need ✓ Acceptance and openness to diversity ✓ Welcoming of parents and family members as resources and partners in treatment ✓ Recognition of the value of the consumer and community input into programs and policies	✓ Funding mechanisms ✓ Understanding the organization's operation and interrelations of various agencies in systems ✓ Knowledge of the stigma of mental illness/ emotional disturbance ✓ Role of religious beliefs ✓ Role of community history, provider relations, and political considerations	✓ Multi-disciplinary collaboration skills ✓ Treatment planning skills ✓ State-of-the-art clinical and diagnostic skills ✓ Assessment of family functioning ✓ Treatment of substance disorders ✓ Systems evaluation and intervention ✓ Administrative skills ✓ Total Quality Management Skills
AACAP's, *Best Principles for Managed Care Medicaid RFP's...*				✓ (although minimal) There is repeated mention of the general areas of skill training needed by personnel who will provide services.

CORE COMPETENCIES IDENTIFIED OR DEFINED BY AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION DOCUMENTS

DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
AMHCA's National Standards for the Clinical Mental Health Counseling and *AMHCA's Code of Ethics*	✓ The values of providing high quality services to consumers are implied in some instances and stated in others. For example, concerning confidentiality, the standards state that "trust between clinical mental health counselors and their clients is an essential ingredient of the counseling process."	✓ One example which demonstrates a certain attitude has to do with the admonition to mental health counselors to accurately represent themselves to consumers.	✓ The Education and Training Standards for Clinical Mental Health Counselors encompass the knowledge to be mastered in the core curriculum and supervised clinical instruction.	✓ Attention to skills is emphasized in the determination of the National Clinical Examination and the Work Sample representing the competency-based criterion, as the standard for acquisition of knowledge.

	In other areas, such as the service environment, the admonitions to provide consumers with a wholesome environment speaks to the value of making consumers comfortable in the surroundings in which the mental health services are offered.			

CORE COMPETENCIES IDENTIFIED OR DEFINED BY NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS (NASP) DOCUMENTS

DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
NASP Professional Conduct Manual: Principles for Professional Ethics & Standards for the Provision of School Psychological Services	✓ Respect for human dignity ✓ Advocacy for students/consumers ✓ Enhancement of the human condition, particularly with regards to children	✓ Promote mental health and facilitate learning ✓ Accept responsibility for appropriateness of treatment and professional practice ✓ Establish and maintain relationships with other individuals	✓ Completion of school psychology training program which meets NASP criteria ✓ Knowledge of and coordination with other mental health providers ✓ Participation in continuing professional development	✓ Design and develop procedures for preventing disorders, promoting mental health, and learning ✓ Provide training on issues of human learning development and behavior ✓ Provide direct services to enhance the mental health, behavior, personality, social competence, and educational status of the student/consumer

DOCUMENT				

NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
26 *NASP Standards for Training and Field Placement Programs in School Psychology*	✓ Respect for the dignity and worth of each individual ✓ Commitment to understanding and responding to human diversity ✓ Commitment to understanding of human behavior for the purpose of promoting human welfare	✓ Promotion of positive educational and mental health practices ✓ Ethical responsibility ✓ Initiative and dependability	✓ Foundation in the knowledge base for the discipline of psychology and the discipline of education ✓ Demonstrated knowledge and professional expertise to collaborate with families and school- and community-based professionals in designing, implementing, and evaluating health needs of children and youth ✓ Continuing education requirements	✓ Demonstrate ability to integrate knowledge and skills in providing a broad range of school psychological services ✓ Demonstrated competency in the areas of professional work characteristics, knowledge base, and applied professional practice ✓ Demonstrated competency in research

CORE COMPETENCIES IDENTIFIED BY SOCIAL WORK DOCUMENTS

DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
NASW, *Standards for School Social Work Services*	✓ Primacy of consumer's interest ✓ Confidentiality and privacy ✓ Respect, fairness, and courtesy ✓ Development of knowledge	✓ Recognition of basic human rights ✓ Willingness to accept some degree of personal and professional risk ✓ Recognition that change is constant	✓ Human behavior and social environment ✓ Nature of systematic assessment and investigation and their essential functions in social work ✓ Methods of social work intervention ✓ Organization and structure of the local education agency ✓ Understanding of the characteristics and reciprocal influences of home, school, and community	✓ Interviewing and other forms of oral and written communication ✓ Systematically observing and assessing needs, characteristics, and interactions of children, families, personnel in the education agency, and community members ✓ Collecting appropriate information to document and assess aspects of the biological, medical, psychological, cultural, sociological, emotional, legal, and environmental that affect the child's learning ✓ Selecting and applying the most effective intervention methods and techniques ✓ Advocating for the needs of children and families

28 NASW's *Standards for Social Work Practice in Child Protection* and Clark and Grossman, *The California Competency-Based Child Welfare Curriculum Project Report...*	✓ The social worker's primary responsibility is to consumers. ✓ The social worker should make every effort to foster maximum self-determination on the part of consumers. ✓ The social worker should respect the privacy of consumers and the confidentiality of all information obtained in the course of professional service. ✓ The social worker should treat colleagues with respect, courage, fairness, and good faith. ✓ The social worker should uphold and advance the values, ethics, knowledge, and mission of the profession.	✓ Assume multiple professional roles and acceptance of authority inherent in those roles ✓ Promote collaborative working relationships among community agencies ✓ Strive to become and remain proficient in professional practice ✓ Acceptance of one's own humanness ✓ Acknowledgement of one's own values, attitudes, and biases about children, families, child-rearing practices, and ethnic and cultural differences along with awareness of the potential impact of these personal feelings upon professional decision making ✓ Belief in the capacity of people to change and the desire of most parents to be good parents ✓ Recognition of the dignity of the child as an individual with both a right to adequate care and a stake in continuing family relationships ✓ Commitment to the child's family as the	✓ Knowledge basic to the social work profession and an understanding of the social institutions, organizations, and resources serving children and families ✓ Children and families and the dynamics of child abuse and neglect ✓ State's abuse and neglect legislation as well as legislation pertaining to child custody, guardianship, and adoption ✓ Legal definitions of physical, sexual, and emotional abuse and neglect and the legal bases of authority to protect the child	✓ Generic social work skills ✓ Immediate assessment of reports about endangered children, including through reports, telephone, and face-to-face interviews ✓ Application of knowledge about indicators of child abuse and neglect ✓ Evaluation of high risk situations coupled with appropriate measures to ensure personal safety ✓ Acceptance of and appropriate use of legal and professional authority ✓ Provision of timely and appropriate measures directed towards ensuring the child's safety and maintaining the family ✓ Follow-up communication with the reporter while safeguarding family confidentiality and privacy rights

		preferred unit of child rearing and nurturing		
DOCUMENT NAME	**VALUES**	**ATTITUDES**	**KNOWLEDGE**	**SKILLS**
NASW'S *Social Work Perspective on Managed Care for Mental Health and Substance Abuse Treatment*	✓ Many value statements embedded in document (e.g., geographical accessibility, multi-cultural sensitivity, competence, treatment first and financial considerations second, confidentiality)	✓ Attitudes presumed to be consonant with values (not clearly stated however)	✓ Most are not specific, although some sections, such as the elements of the treatment planning process could form the basis for standards or training materials	✓ Mentions certain skills such as the ability to clearly articulate consumer needs, develop treatment plans, and gear work to outcomes. Does not provide specific content in these areas
29 NASW, *Standards for the Practice of Social Work with Adolescents*	✓ Maintain high standards of personal conduct in the capacity or identity as social worker ✓ Strive to become and remain proficient in professional practice and the performance of professional functions ✓ Act in accordance with the highest standards of professional integrity ✓ Foster maximum self-determination on the part of consumers ✓ Respect the privacy of consumers ✓ Treat colleagues with respect, courtesy, fairness, and good faith	✓ Values relate to attitudes.	✓ Adolescent development ✓ The needs of adolescents, social institutions, organizations, and resources within a community that provide services for adolescents and their families ✓ Family dynamics ✓ Culturally competent service delivery ✓ Legal, regulatory, and administrative requirements and resources for youths and their families	✓ Advocacy ✓ Assessment of youth and family strengths, risk factors, and presenting problems ✓ Assessment of potential use of available services and interventions ✓ Individual evaluations of the adolescent's progress and consultation following the evaluation ✓ Appraisal of the youth's success and failures when the case is closed and assessment of alternatives that were available for the case plan

CORE COMPETENCIES IDENTIFIED FOR SPECIFIC PRACTICE AREAS

DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
Rycus and Hughes, *Competencies for Child Welfare Case Workers*	✓ The worker knows the values of family-centered child welfare practice, including family preservation, permanence for children, preservation of parents' and children's rights, consumer self-determination, reasonable efforts, and respect for individual and cultural differences (only one example - the document is filled with such statements).	✓ The worker is aware of his/her own emotional responses to sexual abuse and of the potential for these responses to interfere with the casework process.	✓ The worker understands the proper role of the juvenile court system in child welfare and knows how to use the juvenile court to protect children.	✓ The worker can assess the needs of children requiring foster or adoptive placement and can select the most appropriate, least restrictive, most homelike, culturally relevant placement setting to meeting the child's developmental and treatment needs.

CORE COMPETENCIES IDENTIFIED OR DEFINED IN TRAINING CURRICULA

DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
Behar, Zipper, Weil (Eds.), *Case Management for Children's Mental Health: A Training Curriculum for Child Serving Agencies*	✓ Cultural competence ✓ The family as an active participant in assessment and problem solving ✓ The case manager as a collaborator within a community context ✓ The multiple roles of the case manager to enable, empower, and advocate for families ✓ The importance of comprehensive, ecological assessments	✓ Respecting and appreciating culture and diversity ✓ Being cognizant of one's own culture and how it affects one's interactions with others ✓ Respect for the capacities of families and children ✓ Recognition of the ways that systems can prevent barriers to effective services	Fourteen modules: ✓ Introduction to Case Management (values, attitudes, principles of effective case management) ✓ The Basics of Case Management (role of the case manager; paradigm shift for services; definitions of case management; basic values and beliefs; a continuum of services) ✓ The Service System in our State ✓ Diversity and Cultural Competence ✓ The Case Manager, the Process, and the Child Serving System (interpersonal and inter-agency collaboration, system constraints and facilitators, advocacy, evaluating outcomes) ✓ Case Management Functions and Process: Collaborating with Families ✓ Case Management Functions and Process: Collaborating with Service Providers ✓ Crisis Intervention ✓ A Mental Health Perspective on Assessment and Intervention ✓ Developing Teams and Facilitating Team Functioning ✓ Service Coordination in Early Intervention ✓ Parents as Advocates and Case Managers ✓ Supervision and Cross-System	

			Management	

DOCUMENT NAME	VALUES	ATTITUDES	KNOWLEDGE	SKILLS
32 Early & Litzelfelner, University of Kansas School of Social Welfare, *Crisis Intervention with Children and Adolescents with Severe Emotional Disturbances or Mental Illness and Their Families: A Training Curriculum*	✓ The values on which the curriculum is based are explicit, both in trainer instructions and in handouts and resource materials. The curriculum presents fundamental values related to families and family strengths, but does not provide sufficient opportunity to explore these values and to help trainees fully explore their validity. ✓ States and reinforces the value of cultural competence	✓ The curriculum models attitudes of collaboration; respect for consumers; belief in consumers' autonomy in identifying solutions; empathy and respect for the feelings and needs of youth in crisis; and the responsibility of professionals as advocates and enablers.	✓ Knowledge of a sequence of intervention strategies, particularly to deal with aggressive or suicidal behavior on the part of a child or youth; knowledge of strategies to de-escalate such events; strategies to prevent worker stress or burn-out. Handouts provide comprehensive information on various cultural and ethnic groups.	✓ Basic interviewing and listening skills ✓ De-escalation skills

IV. CHALLENGES AND RECOMMENDATIONS FOR ACTION

It is clear from this review that there are many voices emerging during this period of rapid change. A next important step emanating from this process is to develop, through a consensus process, standard practice protocols and recommended core competencies for child and adolescent mental health based on best practice and the collective practical wisdom about how clinicians and care givers can most successfully serve children and families.

Ultimately, the goal is to achieve a coherent, systemic approach whereby standards, accrediting and credentialing criteria, practice guidelines, provider competencies, outcome and performance indicators, and accountability processes for child and adolescent mental health can operate synergistically to achieve quality care and good outcomes.

The next five to ten years are critical in developing and improving the tools and the capability of the workforce needed for the changes that are occurring in the service delivery system to ensure that quality of care is enhanced and not sacrificed in the interest of cost containment. This review of materials shows that some important progress has been made. However, the challenges that need to be addressed for those concerned about delivering quality, cost-effective care to children and adolescents with mental, emotional, and behavioral disorders and their families are daunting. These challenges include:

- The development of broadly-endorsed standards and a report card for child and adolescent mental health;
- Practice guidelines that include protocols for meaningful involvement of families at all levels from policy to treatment, culturally-competent strategies and approaches, strength-based assessments, care criteria for the full range of services and supports needed by children and families with guidance for what is most clinically appropriate for different needs and situations, and integration with other service systems;
- The development of appropriate outcomes for children and adolescents and processes for measurement and accountability;
- Performance indicators for providers;
- Continued expansion of the research base;
- Continued development of the service array; and
- Intensified efforts by universities and agencies to provide relevant education and training for the child and adolescent workforce.

V. REVIEW AND CRITIQUE OF AVAILABLE MATERIALS

Each item reviewed includes the following: a summary of the objectives of the document (if stated), a description of the content, the process of development, strengths of the material, and gaps/weaknesses identified.

Standards of Care Developed by Stakeholder Groups

This section includes standards of care for the delivery of quality services from the perspective of consumers, families, government, purchasers including government, professional groups, providers, managed care organizations, and accrediting bodies.

Federal Government[1]

1. Center for Mental Health Services. (Undated). *Principles for system of managed care.* [Brochure]. Rockville, MD: Author, 2 pages.

   This brochure briefly outlines the role of the Substance Abuse and Mental Health Service Administration's Center for Mental Health Services in promoting policies for a managed care system, particularly with respect to adults with serious mental illness and children with serious emotional disturbances. The document lists guidelines and principles from a government perspective including 1) quality of care, 2) consumer participation and rights, 3) accessibility, 4) affordability, 5) linkages and integration, and 6) accountability. This document provides a clear position statement, but it does not focus specifically on children's issues. It is more generic in nature. It would be strengthened if it included back-up reference materials.

2. *Consumer-oriented mental health report card: The final report of the Mental Health Statistics Improvement Program (MHSIP) task force on a consumer-oriented mental health report card.* (1996, April). A collaborative effort of the MHSIP community and the Center for Mental Health Services, 145 pages.

   This report represents a "work in progress" on a comprehensive mental health services report card to assess the quality and costs of mental health and substance abuse services. While adults with serious mental illnesses are the major focus of the report card, indicators and measures relevant

[1]The Center for Mental Health Services and the National Institute for Mental Health have provided funding support and review of a number of materials developed for the Child and Adolescent Service System Program (CASSP) by the National Technical Assistance Center for Children's Mental Health at the Georgetown University Child Development Center articulating principles and standards for service delivery for children and adolescents with serious emotional disorders, and those at risk. These materials were not reviewed for this document but are included in Appendix B: Selected References and Bibliography. The principles and standards established by the American Academy of Child and Adolescent Psychiatry, reviewed on page 39, were also developed through funding support from the Center for Mental Health Services.

to children with serious emotional disturbances, adults and children with other mental disorders, and adults with dual diagnosis of a mental illness and substance abuse disorder are also included.

The authors believe the unique features of the report card are that it is 1) consumer-oriented; 2) based on research and explicit values; 3) focused on, but not limited to, serious mental illness; 4) designed to emphasize the outcomes of mental health treatment; and 5) conscious to related costs and staff burden. The data are to be collected from the providers' administrative database, clinician assessments and medical records, and consumer self-report instruments. The report recommends that states or payers who are purchasing the services be responsible for administering the consumer survey (as opposed to the service providers). It appears that the data that will be used to pilot the report card will be selected at admission into treatment, three months after treatment begins (or at the end of treatment), and at a year from admission for those still receiving services.

The data contained in the report card are to be used to determine how well a mental health provider or service system is performing relative to four domains: access, appropriateness, outcomes, and prevention. Consumer satisfaction was dropped as a separate domain because it was felt it was represented in each of the other domains.

This report card represents a very good working model for the development of a comprehensive report card, especially for adults. The major strengths are the emphasis on consumer feedback, the utilization of previous research, and the incorporation of many meaningful indicators within four relevant domains. The inclusion of several empirically-based, outcome measures (along with a presentation of their psychometric properties) and the plan to standardize the consumer survey are also strong components of the model. Finally, it should be noted that the entire report is well-organized and presented in a very user-friendly format.

Much of the report card recognizes the importance of nonprofessional services (support groups, consumer-run services, etc.). However, numerous questions are driven by the medical model (e.g., average time until the first face-to-face meeting with a mental health professional; percentage of consumers who report that physicians, mental health therapists, or case managers can be reached easily; percentage of people who had only one mental health contact in a year). What about access to nonprofessional services that promote recovery?

The following weaknesses are noted: some procedures minimize issues of reliability and validity; and, it is unclear what is meant by "known and accepted best-practice guidelines." Who established best practice? The item pertains to the American Psychiatric Association (APA) guidelines for the treatment of major depression. Are there other "best practices" and, if so, who makes that determination?

In summary, the report card described in this report contains many positive attributes. As a "work in progress," it should continue to be refined and tested. It clearly represents progress in the effort to make mental health services more accountable and effective.

State Government

3. State of Delaware, Division of Mental Health Services, the Department of Services for Children, Youth, and Their Families. (Undated). *Standards: Quality improvement program*. Series A, Vol. 1, 20 pages.

   This quality improvement plan establishes standards and procedures to monitor and evaluate the quality, timeliness, cost-effectiveness, and appropriateness of consumer care 1) to insure that children and adolescents receive clinically appropriate care at the least restrictive level necessary, 2) to identify opportunities to improve care, and 3) to resolve identified problems. The plan applies to all clinical and administrative components of Delaware's Division of Child Mental Health Services and to providers under contract.

   These standards are broad in content, including such areas as process of quality assessment, accountability to the governing body, resources, credentialing, utilization review, consumer rights, etc, but they are not specific. For example, the standards do not delineate the outcomes to be achieved or who should constitute the multi-disciplinary clinical teams. The credentialing section seems to be very medically-oriented. The *Client Rights and Responsibilities* section includes standards to assess member satisfaction, but there does not seem to be consumer or family involvement on the governing body. While the authors state that these standards are for ensuring quality care to children and their families, the language and the standards themselves are very adult-oriented. They also do not address coordination with other child-serving systems and agencies.

4. State Mental Health Representatives for Children and Youth. (1995, July 14, Draft). *Successful integration of system of care development with managed behavioral healthcare technologies in public children's mental health*. Alexandria, VA: Author, 11 pages.

   This document has been prepared by the State Mental Health Representatives for Children and Youth (SMHRCY). Its purpose is to highlight a set of issues important to the delivery of mental health services and supports on behalf of children, adolescents, and their families within the context of state-level initiatives for Medicaid re-structuring and the introduction or expansion of managed behavioral healthcare technologies in the public sector. The document enhances a companion document, prepared through a partnership of the National Association of State Mental Health Program Directors (NASMHPD), of which SMHRCY is one division, and the American Managed Behavioral Healthcare Association (AMBHA), entitled *Public Mental Health Systems, Medicaid Re-Structuring and Managed Behavioral Healthcare*.

   The document addresses issues including 1) *Managed Care and Children's Mental Health*; 2) *Critical Issues*: a) the unique mental health needs of children and adolescents, b) systems of care development based on interagency collaboration, c) cultural competence as an essential element of managed care, d) the necessary role of families, e) individualized and need-driven interventions

on behalf of the child/family; and 3) *Accountability*.

This document provides an important statement of principles to guide state mental health authorities who are purchasers of managed care, as well as other key constituencies in shaping a managed behavioral health care system. The document endorses the CASSP system of care philosophy and principles as a framework for implementing managed care technology for vulnerable populations of children, adolescents, and families served by the public sector. This document, as it states, is a work in progress. It would be strengthened considerably by including more detail on outcomes, guidelines for contracts, and performance indicators.

5. State of New Mexico, Children, Youth and Families Department, Office of Managed Care Services. (1995, August 29). *Certification standards for children and adolescent mental health services,* 68 pages.

   This material comprises certification standards for child and adolescent mental health services in the State of New Mexico. It provides overall requirements for the agencies and institutions serving the mental health needs of children, adolescents, and families. The document is divided into nine sections. The first eight sections describe the policies and procedures for an agency providing the above-mentioned services and include *Agency in the Community; Agency Governance and Administration; Personnel; Quality Assurance & Utilization Review; Regulatory Compliance for Program Operation including Health, Safety, and Physical Plan Requirements; Client Rights and Protection; Intake, Assessment, and Treatment Planning; Client Information, Confidentiality, and Case Review.* The ninth section provides more specific policies and procedures for *Case Management; Day Treatment; Behavior Management Skills Development Services; Treatment Foster Care;* and *Residential Treatment Services.*

   This document addresses general precepts relevant to child and adolescent mental health services and gives adequate coverage to child and adolescent rights, consumer protection, case management, and treatment foster care. However, the document does not address outpatient psychiatric mental health clinics, emergency crisis intervention services, or flexible, wrap-around services and supports. The training, supervision, and quality assurance sections need to be more fully developed and strengthened.

Families/Consumers

6. Bazelon Center for Mental Health Law & the Federation of Families for Children's Mental Health. (1996). *A family advocate's guide: Managed behavioral health care for children and youth.* Washington, DC: Bazelon Center for Mental Health Law.

   This guide offers principles of how managed care should work for children with mental, emotional, or behavioral disorders and a checklist of strategies to assure that state systems adhere to these principles. An appendix includes handouts for educating policy makers and managed care administrators.

This document was not published in time to be reviewed by the Child and Adolescent Panel, but is referenced because it appears to be a timely addition to the literature.

7. Bazelon Center for Mental Health Law & the Federation of Families for Children's Mental Health. (1996). *Your family and managed care: A guide for families of children with mental, emotional, or behavioral disorders.* Washington, DC: Bazelon Center for Mental Health Law.

   This 16-page booklet explains the workings, advantages, and pitfalls of managed care for children with mental, emotional, or behavioral disorders and their families. Sections are titled, *How Managed Care Can Improve Your Child's Access to Services; How Does Managed Care Control Costs?; What You Can Do; What to Watch Out For;* and, as a family report card, *Checklist for a Managed Care Plan.*

   This document was not published in time to be reviewed by the Child and Adolescent Panel, but is referenced because it appears to be a timely addition to the literature.

8. Federation of Families for Children's Mental Health. (1995, July 7). *Principles of family involvement in the development and operation of managed health and mental health systems for children and youth,* 3 pages.

   This document lists guidelines and principles from the perspective of families defining the roles for families in the development and operation of managed care. It addresses the following policy issues: families as part of the decision-making team, service-related concerns, and financial considerations to cover costs of family involvement.

   This document represents a strong and cogent statement of principles focusing on key elements of family involvement and managed care. Its limited and succinct focus is its strength but also is a weakness. Training, outcomes, and quality assurance are briefly mentioned. These principles could be enhanced if accompanied by benchmarks and supplementary material providing guidelines and implementation strategies.

9. Malloy, M. (1995, April). *Mental illness and managed care: A primer for families and consumers*. Arlington, VA: National Alliance for the Mentally Ill, 80 pages.

   This manual provides basic information about managed care and the implications of managed care in public-sector mental health services. Although written for advocates, the tone and material takes an objective view of almost all areas so it has a much broader usage. The *Introduction* focuses on the interests of National Alliance for the Mentally Ill (NAMI). The major body of the piece provides very clear, detailed information on a wide range of aspects of mental health and managed care with numerous examples provided throughout the text. Topics addressed include what managed care is, how mental health managed care is implemented, public mental health systems and managed care, Medicaid waivers, and state experiences including health reforms

currently underway. At the end, there is a checklist of ideal attributes of a system intended as a guide to NAMI advocates as they work to influence their state's initiatives.

While child examples are given, this document does not specifically address children's issues. A companion volume focusing on child and adolescent issues would be useful. Also this document, as its title states, is a primer on managed care; it does not represent a set of principles or standards *per se*.

Professional Groups and Key Disciplines

10. American Academy of Child and Adolescent Psychiatry. (1996, February). *Best principles for managed care Medicaid RFP's: How decision-makers can select and monitor high quality programs!* Washington, DC: Author, 21 pages.

    This document, with support from the CMHS, was developed be the American Academy of Child and Adolescent Psychiatry's (AACAP's) *Task Force on Community Systems of Care for Children with Serious Emotional Disturbances* to provide guidelines for development of requests for proposals (RFP's) for managed behavioral health care paid for by Medicaid. This document was written by child psychiatrists and is intended to be used to "assist decision-makers in selecting managed mental health care systems." It is written from the perspective of the psychiatrist or clinically trained mental health professional. The document is organized around ten aspects of managed care systems. For most sections, there is an opening statement followed by a bulleted list of items specifying criteria, procedures, policies, or actions that should be incorporated into the RFP. The ten aspects are: 1) *Governance*; 2) *Benefit Design*; 3) *Access to Services*; 4) *Care Plan Development*; 5) *Triage and Assessment*; 6) *Treatment and Other Services*; 7) *Case Management*; 8) *Quality Assurance/Improvement*; 9) *Provider Support Services*; and 10) *Information Management*.

    This document addresses many issues consonant with the CASSP values and principles and actually contains a statement of those values and principles. Sections call for family involvement in assessment and treatment, consumer- and family-centered care plans, and the protection of family rights; a comprehensive array of services, which are delineated in the document; access that takes into consideration developmental, socio-economic, and cultural needs; early intervention; individualized care plans; and a holistic assessment process. There is a specific section for services to "high utilizers". These principles from child psychiatry convey a positive message to the field. The list of task force members and consultants who developed the principles includes many individuals well-versed in child and adolescent mental health, but does not include any family members. A truly family-centered approach would require family members to play a significant role in development.

11. National Association of Social Workers, National Council on the Practice of Clinical Social Work. (1993, June). *The social work perspective on managed care for mental health and substance abuse treatment.* Washington, DC: National Association of Social Workers, 12 pages.

The document includes guidelines for mental health and substance abuse treatment developed for managed care organizations, clinical social workers, and social workers functioning as managed care executives and staff. It offers guidance to managed care organizations, payers, and regulators on the development of consumer sensitive operations; to clinical social workers on methods to enhance their functioning in this environment in an ethical manner; and to social work executives and staff of managed care organizations to support their professional identity in these settings. The document includes the following sections: 1) *Overview*, 2) *Guidelines for Managed Care Organizations*, 3) *Guidelines for the Clinical Social Work Provider*, 4) *Guidelines for Social Workers Functioning as Managed Care Executives and Staff*, 5) *Summary*, and 6) *References*.

These guidelines provide good, general information that is useful for those attempting to develop standards and training materials. The guidelines for managed care organizations include protections for consumers, involvement of consumers and providers in the development of policy, attention to cultural issues, and benefit design at the three levels. Guidelines for clinical social work providers include some specificity about treatment planning, consumer involvement, confidentiality, possible conflicts between cost considerations and needs of consumers, and provider responsibilities.

These guidelines are not specific to children, adolescents, and their families; therefore, they do not address issues of particular concern for children such as multi-agency involvement and service coordination. Overall, they reflect a more traditional service approach focusing on psychotherapy. Concepts and approaches such as system of care and family support issues are not discussed. The document also does not address specific competencies, although guidance is provided in areas such as confidentiality, consumer rights, and social work responsibilities.

Managed Behavioral Health Care Industry

12. American Managed Behavioral Healthcare Association . (1995, August). *Performance measures for managed behavioral healthcare programs.* Washington, DC: Author, 27 pages.

The American Managed Behavioral Healthcare Association (AMBHA) was established in 1994 and is comprised of 13 managed behavioral healthcare organizations. Its stated goals are to 1) demonstrate the value and validity of managed behavioral healthcare; 2) promote parity for mental illness and addiction disorders in benefit coverage; and 3) promote open competition based on documented performance in the areas of positive clinical outcomes and consumer satisfaction.

This document provides a framework for the development of standardized report card performance indicators that can be used to assess the value of managed behavioral healthcare services delivered through the AMBHA member organizations. The following three principles guided the authors' efforts when developing the document: that the performance indicators must be "meaningful, measurable, and manageable."

The strength of this document is its overall objective. There is a critical need for good quantitative and qualitative data in the following three domains that are the focus of the report card: 1) *Access to Care* which includes information on *Utilization-Based Indicators* and *Structural Indicators;* 2) *Consumer Satisfaction* which includes *Access, Intake, Clinical Care, Outcome of Care,* and *Global Satisfaction;* and 3) *Quality of Care* which includes *Effectiveness, Efficiency,* and *Appropriateness.*

The performance measures appear to be designed to meet the needs of a specific, medically-driven health care program and the emphasis is primarily on adults. The only child-specific measure is, "family visits for children." It is very focused on professional services for specific diagnostic categories (e.g., major depressive disorders, substance abuse, and schizophrenia); it assumes that all clients who are discharged from an inpatient psychiatric facility will require outpatient treatment (or the quality of care is not effective); the only significant care to be evaluated by the consumer is that of the "therapist"; and the primary measure of success is a decline in re-admissions. The performance measures do not focus on some of the more promising, non-medical, psychiatric rehabilitation services. There are also major issues with respect to the reliability and validity of the performance measures that are described.

Provider Accrediting Bodies

13. Council on Accreditation. (Review copy, to be published 1997). *COA draft revised standards - Volume I: Behavioral healthcare standards and Volume II: Community support and education services.* [In disk format]. New York: Author.

The Council on Accreditation (COA) is an independent not-for-profit organization that accredits approximately 1000 behavioral health care programs and 3000 social service programs.

This is a comprehensive document establishing standards for the accreditation of a broad range of behavioral heath care and social service programs for all ages. The material reviewed is a draft with final standards to be published in the Spring of 1997. Volume I addresses behavioral health care and includes sections entitled *Generic Standards* and *Service Standards*. The generic standards entail: *Organizational Purpose and Relationship to the Community, Continuous Quality Improvement Process, Organizational Stability, Management of Human Resources, Quality of the Service Environment, Financial and Risk Management, Person and Family-Centered Assessment and Planning, Person and Family-Centered Service Delivery Processes,* and *Professional Practices*. The *Services Standards* section includes *Mental Health and Family and Individual Counseling Services, Substance Abuse Services, Crisis Services, Child and Family Services, Day Programs,* and *Residential Programs.* Volume II, *Community Education and Support Services* also is divided into two sections: *Generic Standards* and *Service Standards.* The services include *Advocacy and Access Services, Community-Based Education Services,* and *Community-Based Support Services*.

The document addresses both adults and children with attention to the unique aspects of serving both these populations. The standards incorporate the principles of a system of care; emphasize involving and empowering families, building on strengths, attending to cultural and racial differences; and provide detailed specifications to better ensure implementation.

The person and family-centered assessment and planning section calls for identifying the needs expressed and the problems facing the individual and families and engaging them in mutual efforts to achieve desired outcomes. The assessment includes consideration of family strengths as well as racial, ethnic, and cultural background; adaptations to address the needs of special populations; and a logical relationship between assessment and the treatment plan. Treatment plans must be goal-directed and strengths-based. Complex needs require an interdisciplinary team. Service implementation should be designed to support, strengthen, and empower families and focus on family reunification, stabilizing families, and/or permanency. Service planning should involve (to the degree possible) full participation of the person served and the family with persons actively asked what they wish and given options. Standards also address least restrictive environment, care coordination and monitoring, continuity of care, aftercare planning, and connections and involvement with persons who can provide community support. Service planning includes addressing both education and vocational needs.

Guidelines are provided for a broad array of services including counseling, home-based services, case management, day treatment, therapeutic foster care, respite care, independent living programs, wilderness camps, and residential services -- both crisis and more long-term. The service areas address standards for services, administrative practices, human resources, and outcomes. The standards for behavioral health care recognize multiple qualifications for clinical practice and address personnel development programs to support program goals. Standards are also established for administrative practices to support the achievement of program goals. Outcomes delineated cover multiple dimensions including psychosocial functioning and empowering family functioning within the context of culture and community.

These standards for organizations are comprehensive and incorporate many elements and features of best practice for serving children and families. They provide a more holistic approach to assessment, planning, and treatment of individuals and families than those standards that are more oriented around a medical model of practice.

l sets forth performance standards for accreditation for organizations providing mental
stance abuse, and developmental disability services. This manual represents the
n's transition from standards organized around an organization's program and services
ls organized around clinical and organizational functions focused on actual

14. Joint Commission on Accreditation of Healthcare Organizations. (1994). *1995 MHM: Accreditation manual for mental health, chemical dependency, and mental retardation/ developmental disabilities services, Volume 1: Standards*. Oakbrook Terrace, IL: Author

performance and outcomes. The standards are divided into two sections: *Individualized Focused Functions*, directed to care of the individual, and *Organizational Functions*, addressing organizational management.

These standards are primarily adult-focused. Sections relating to children are minimal and very specific such as conducting special assessments of children and adolescents and promoting access to appropriate educational services. The standards reflect important concepts such as including in the treatment plan a specific plan for involving the family and viewing care as part of a continuum enabling individuals to have access to an integrated system of settings, services, and care levels. The continuum of care is defined as "matching the individual's/patient's needs with the appropriate level and type of medical, psychological, health, or social services."

15. Joint Commission on Accreditation of Healthcare Organizations. (1995). *1996 Comprehensive accreditation manual for health care networks (CAMHCN)*. Oakbrook Terrace, IL: Author.

    This material represents standards for health care delivery organizations regardless of their organizational form (HMO's, PPO's, IDS) from the perspective of the U.S.'s first accrediting agency for hospitals. This document describes the national consensus expectations regarding the performance of health care delivery organizations to be well-managed, provide excellent care, and be publicly accountable for their performance. The manual is designed to serve as a guide for and measure of good management and clinical care. The manual is divided into many sections including *Accreditation Policies and Procedures; The Accreditation Decision Process; Standards, Scoring Guidelines, and Aggregation Rules; Appendices for Unaccredited Components*; and *Appendices on Interim Life Safety Measures and the Accreditation and Appeal Procedures*.

    The JCAHCO CAMHCN standards are well-organized and detailed in both standard requirements and scoring guidelines. The following are some strengths of the JCAHCO survey process for networks: public notice to members, focus on leadership, performance measures, and performance improvement.

    Gaps and weaknesses in the JCAHCO CAMHCN standards include: 1) lack of specific standard for mental health; 2) lack of specific standards for age-specific issues (e.g., children, adolescents, geriatrics); 3) lack of specific standards to address new and/or alternative services (e.g., wrap-around services); 4) failure to address member involvement in governing and advisory boards; 5) lack of emphasis on consumer recovery and rehabilitation; 6) lack of emphasis on consumer empowerment and consumer satisfaction; 7) absence of a standard related to <u>expanding</u> the continuum of service to meet members needs (standard CC.1 and CC.2 only address meeting members needs through services <u>available</u> in the continuum); and 8) lack of specific standards related to access.

16. National Committee for Quality Assurance. (1996, April 1). *Draft accreditation standards for managed behavioral healthcare organizations*. Washington, DC: Author, 83 pages.

This document provides proposed accreditation standards for mental health services for managed behavioral healthcare organizations, a public comment form, and a form for requesting application. The standards were developed with input from consumers, employers, purchasers, managed behavioral healthcare representatives, key professionals, and trade associations. Much attention is given to structure and process for creating standards and for the review process. Topics include: accessibility, availability and referral, credentialing of providers, members' rights and responsibilities, complaint resolution, confidentiality, records and records treatment review. Appendices include *Guidelines for Treatment Record Review* and a *Glossary*. The most detailed and specific information about the "parameters" of mental health services is in a section about preventive screening and education services (pp. 51-52).

This document is well-organized and enjoins managed care organizations to develop standards and procedures for reviewing compliance and self-monitoring. Any training that is developed for providers should at least reference these standards and might specifically include or examine what they have to say about issues such as access, confidentiality, etc.

For the purposes of this project, this document mostly lacks specificity about provider values, knowledge, attitudes, and skills. Much is left up to other credentialing processes and bodies to develop and monitor those issues; i.e., the professional training and credentialing groups are seen as legitimatizing bodies and assessment of preparedness/fitness is done through the credentialing process. These standards do not provide specificity, except around areas such as confidentiality and informed consent, addressing complaints, etc.

Clinical Guidelines/Protocols and Level of Care Criteria Developed by Stakeholder Groups

This section includes clinical guidelines, protocols, and level of care criteria for assessing and treating child and adolescent disorders and/or for making level of care and treatment decisions. These guidelines are developed by managed care organizations, professional organizations, state and federal governments, and other provider systems.

Federal Government

17. Science Applications International Corporation. (1995, November). *Mental health quality monitoring screens and utilization review criteria.* Project funded by the Department of Defense, Health Affairs, 238 pages.

    Science Applications International Corporation (SAIC) developed this manual for the Department of Defense to determine tools that can be used by the federal government to help manage quality and utilization of mental health and chemical dependency services provided under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The tools consist of quality monitoring (QM) criteria and utilization review (UR) criteria developed from selected clinical practice guidelines published under the auspices of professional and industry organizations. Three bodies (the Institute of Medicine, the American College of Physicians, and

the American Psychological Association) suggested criteria for evaluation of the practice guidelines. The three basic criteria include 1) Is the strength of empirical evidence evaluated? 2) Are controlled empirical studies used in the development of the guidelines? and 3) Is multidisciplinary input included in the process?

The *Children's UR* section includes *Acute Inpatient Hospitalization, Residential Treatment, Partial Hospitalization,* and *Outpatient Treatment.*

The *QM Diagnosis Screens* section includes minimal standards for children for specific diagnoses (anxiety, disruptive behavior, and eating disorders); for example, under anxiety disorders, the treatment plan includes behaviorally specific treatment goals and treatment includes the child's family.

These guidelines provide an excellent foundation, and the methodology undertaken by SAIC for the Department of Defense to develop quality monitoring measures/screens and utilization review criteria is both sound and commendable. Guideline selection criteria were developed by several authoritative bodies (the Institute of Medicine, American College of Physicians, and the American Psychological Association); a comprehensive review of diagnostic specific and clinical methods practice guidelines and utilization review criteria was conducted; these materials were evaluated against the selection criteria to develop quality monitoring (QM) screens and utilization review (UR) criteria; a multidisciplinary team of nationally recognized clinicians reviewed the recommendations; and children and adolescents were included in both the diagnostic and the clinical methods categories. The chart of outpatient utilization review criteria used by managed care companies is a particularly useful summary because it shows which criteria are being applied by which companies and indicates where there is consistency and where there are gaps. The guidelines incorporate such issues as family involvement and respect for cultural and linguistic differences.

But the approach undertaken by SAIC results in a medical model of service delivery and does not adequately reflect the developments in the field including strengths-based needs assessment, strategies for involvement of families, a wide range of service options and supports for children and adolescents, coordination of multiple service systems, and approaches to address cultural competence. Incorporation of these dimensions would be an important next step to strengthening these guidelines.

State Government

18. Commonwealth of Massachusetts, Department of Mental Health. *Standards, clinical criteria, practice guidelines*. Includes the following:

- *Adolescent Intensive Residential Treatment Program Policy*, April 10, 1986
- *Quality Management Standards for Residential Programs,* December 1, 1994
- *Department of Mental Health (Adolescent) Intensive Residential Treatment Program*

Clinical Criteria, April 25, 1996

- *Emergency Program Standards*, April 10, 1996
- *Department of Mental Health Crisis Stabilization Services Clinical Criteria*, April 10, 1996
- *Respite Care Program Standards*, April 1996
- *Clinical Criteria for Respite Care Services*, April 1996
- *Psychiatric Residency/Psychology Internship Training Standards and Performance Indicators*, February 1993
- *Department of Mental Health Document Evaluation Form*, Undated
- *Utilization Management Standards*, May 10, 1996
- *Children, Adolescents and Adults' Interpretive Guidelines for Determining Eligibility for DMH Continuing Care Services*, June 25, 1996
- *Department of Mental Health Child/Adolescent Continuing Care Inpatient Criteria*, April 25, 1996
- *Residential Services Clinical and Rehabilitation Level of Care Criteria for Child, Adolescent and Adult Consumers*, April 25, 1996
- *Department of Mental Health (Children's) Clinically Intensive Residential Treatment Clinical Criteria*, April 25, 1996

This material includes a comprehensive set of state government clinical guidelines and protocols for the provision of an array of mental health services from the Commonwealth of Massachusetts. In as much as the various standards are designed to interlock with one another, the set has been reviewed as a whole. The material includes a variety of standards covering residential treatment (program policy, quality management standards, level of care criteria, and child and adolescent clinical criteria), standards and criteria for emergency, crisis stabilization and respite services, continuing care and continuing inpatient care criteria for children/ adolescents, residency/internship standards and indicators, utilization management standards, and the Department of Mental Health (DMH) evaluation documentation form.

The material reflects a successful effort by the Commonwealth of Massachusetts to establish an integrated management approach to control public expenditures for mental health services. All standards, protocols, and guidelines are designed to reference and support each other, conveying clearly the system's priorities regarding publicly-funded mental health services.

Further, for states interested in a system that is strongly clinically-managed, Massachusetts' system could be easily replicated once the importing state determines that the priorities guiding Massachusetts are consistent with its own.

These standards appear to represent one part of a larger, more complete system of regulation for publicly-funded mental health services across all populations and service types. It is unclear from this material whether these standards serve also as Medicaid standards or whether additional standards exist, complementary to these. The relationship between these standards and those applied to privately-vendored managed care is also unclear.

There appears to be little in this material that addresses the quality of mental health services delivered for children, adolescents, and their families, or that is relevant to training and/or workforce competencies, with the exception of requirements for a psychiatric residency and/or psychology internship.

This set of standards does not appear to be consistent with fundamental values and principles guiding the CASSP System of Care development. The system guided by these standards is not child- or family-centered but clinically-driven; the locus of control is not established at the family or community level but is held by the state DMH; there is no emphasis placed upon cultural context or competence as evidenced by the absence of indicators related to cultural issues.

The model employed is highly directed towards adult services and the standards only occasionally make distinctions between adult or child/adolescent needs. Even when a distinction is drawn between adult and child/adolescent needs, the language of the adult system is employed to describe requirements for child/adolescent programming. The important role of the family is never referenced in the standards/guidelines, other than the guardian's role to sign permission for treatment.

Even though these standards and guidelines are very detailed, much of the detail remains vague, especially those items which might be construed as performance indicators. As an example, the *Psychiatric Residency/Internship Training Standards* include the following performance indicator: "residents/interns systematically identify the most cost-effective way(s) to accomplish treatment objectives in 80% of the cases for which they are responsible." No standards to determine "the most cost-effective way" are provided or suggested.

These standards include a variety of mechanisms designed to clarify responsibility boundaries with other systems (e.g., child welfare and juvenile justice) in order to resolve potential turf disputes between such systems. But the chosen mechanisms appear to maintain barriers instead of enabling a more interactive, partnership approach between systems. The one exception is contained in the *Eligibility Guidelines for Continuing Care*, where exceptions are allowed within "special interagency projects" that may take place in partnership with other systems.

19. State of Delaware, Department of Services for Children, Youth and their Families, Division of Child Mental Health Services. (1994, May). *Standards for professional practice and directions for data collection: Outpatient mental health services, outpatient substance abuse treatment services*, 70 pages.

    This document provides the standards of care for agencies which provide alcohol or other drug abuse (AOD) and outpatient mental health services in the State of Delaware. In order for agencies to be approved as provider agencies for the Department of Services for Children, Youth and Their Families, they must meet the standards in this document. Additionally, it includes the data information requirements for the agencies providing these services. Hence, the document includes standards for professional practices and data collection requirements (including forms)

required by a government (state) entity. In addition to provider agencies (PA), the state may also obtain services from certain individuals in private practice who offer services in languages other than English (including sign language).

Overall, the document provides minimal guidelines for the provision of comprehensive outpatient mental health services. It identifies a range of services, such as Outpatient Mental Health and AOD Treatment, Intensive Crisis Intervention Services, Wrap-Around Services, and Day Treatment Services. It does, however, acknowledge the need for the provision of off-site services, as well as the importance of indirect services in addition to direct services. This document is general in its purview and does not distinguish procedures for specific services (e.g., day treatment, wrap-around, intensive crisis intervention, and outpatient services).

The strengths of this document are primarily the data collection requirements and the uniform forms for referral, intake, monthly progress notes, discharge, discontinuation, and billing. Staff forms are quite inclusive. The documentation for no shows, specific time parameters for treatment, and the distinction made between ethnicity and race are useful. If there are fiscal resources to evaluate the data, the Department should have accurate information on the demographic and clinical characteristics of the children and families being seen, as well as the characteristics of the mental health providers.

The limitations include the following:

- The policies and procedures for provider agencies are general and not specific. No distinctions are made for procedures for the different services. Although Quality Assurance (QA) is covered, specific criteria to measure quality of service or outcome (i.e., as standardized measures) are not employed. Although a QA committee is identified, the frequency of its meetings is not. The same is true for utilization review.
- The need for parental consent as a requirement to treat a child for mental health or alcohol/drug abuse problems appears overly stringent and unrealistic in the current environment. There are children and adolescents in dire need of services, but who are "on their own."
- There is specification for consultation and oversight by psychiatrists and psychologists but not clinical social work. Providers are not required to have specialized experience/training in child and adolescent mental health. Training or continuing education is not mentioned.
- CASSP guidelines are not followed. There is much emphasis on state oversight in the data requirements but little attention to expertise in child and family mental health.

20. State of Delaware, Department of Services for Children, Youth and their Families, Division of Child Mental Health Services. (1995, August 22). *Draft: Mental health services for children and adolescents criteria for hospitalization*, 5 pages.

    This document outlines level of care criteria when hospitalizing children and adolescents for mental health services from the perspective of the state government. It includes *Admission*

Criteria and Exclusion Criteria for Hospitalization, Partial Hospitalization, Residential Treatment Centers (RTC), Day Treatment, and *Aide Services*.
The material is clear and concise, providing enough room for interpretation to prevent rigid exclusion, but it only addresses a limited component of the service system -- hospitalization. For training purposes, it could be valuable in helping learners understand risk assessment and levels within a continuum of care. It states that a child or adolescent who is chronically psychotic or seriously disturbed may require a "different setting," but does not define that setting.

21. State of North Carolina. (1993, July 26/1993, December 6). *Cardinal Child and Adolescent Mental Health Service System criteria to be used as guidance in determining levels of care*, 13 pages.

    This document was developed for the Fort Bragg project to provide guidelines for assignment of children and adolescents to the most appropriate level of care necessary at a point in time. The document is modeled after similar guidelines used by managed care organizations as part of their care management process. The Cardinal document has no preamble or instructions, which may not have been included but, if not available, reflects a major weakness. The document describes three separate criteria for decision making concerning admission, continuation or service, and discharge/transfer for six different services: *Outpatient, In-home Therapy Crisis Stabilization, Day Treatment/Partial Hospitalization Services, Residential Services (therapeutic group homes), Crisis Stabilization Group Home Services*, and *Inpatient Services*.

    For the most part, each of the six sections is based on the same boilerplate language and is only individualized for specific treatment levels in a limited manner. These individualizations are most prominent in the admission section where an attempt is made to spell out specific criteria for requiring that particular level of service. This is rather specific for some (inpatient hospitalization and in-home crisis); however, for day treatment services, the only criterion is need for such service; and for crisis residential, reference is made to another set of guidelines for triage.

    Unlike most managed care organization guidelines, the Cardinal document includes three specific intermediate service modalities: *In-home Therapy Crisis Stabilization, Residential Services* (therapeutic group homes), and *Crisis Stabilization Group Home Services*. These criteria are the first, and perhaps only, attempt at defining level of care for an entire continuum of mental health care. They go well beyond the managed care industry standards for describing the need for these specific services, which, when included at all by private sector managed care organizations, are lumped together as "alternative" or "residential" services.

    These criteria represent a good start, however, they need to be refined to make it more clear who could best benefit from the various non-hospital intensive services. Use of such a document over time would provide an opportunity to refine the criteria and make them more useful. These guidelines focus exclusively on mental health services representing a single aspect of the child's need, rather than a holistic approach to the child's social development and educational needs.

22. State of North Carolina. (1995, November 27). *Levels of care for psychiatric and substance abuse diagnosis (children)*. Prepared for Carolina Alternatives Managed Care Work Group, 24 pages.

    This document describes levels of care for psychiatric and substance abuse diagnosis for children from a state government perspective. The *Levels of Care* material provides a framework that describes specific criteria that must be met to participate in a range of medically necessary services. The *Initial and Continuing Authorization* criteria establish the clinical need which must exist in order to consider re-authorization of a particular treatment regime beyond a set period. The *Levels of Care* and *Initial and Continuing Authorization Criteria* include screening, evaluation, group therapy, individual therapy, day treatment, partial hospitalization, case management, and inpatient hospitalization. Strengths-based services are specified as a focus with an emphasis on rehabilitation, improved adaptability, and prevention of relapse.

    This material is clear and concise. The levels of care provide a rational framework for decision making so that children are served in the most appropriate setting to meet their needs. The language used is "consumer friendly".

    It is not clear if there is an appeals process for families. There also does not seem to be a clear system for peer or team review. The criteria are delineated but do not designate who participates in the decision making.

23. Stelle, L.E. (Undated). *Level of eligibility for child mental health and substance abuse services.* Division of Mental Health/Developmental Disabilities/Substance Abuse, North Carolina Department of Human Resources, 17 pages.

    This document describes level of care or service guidelines from a state government perspective for child mental health and substance abuse (MH & SA) services. It describes state-determined eligibility criteria and forms related to MH & SA services. The initial pages appear to be overheads which need verbal accompaniment in order to be clearly understood. For child mental health level of eligibility, the document is divided into the following sections: *Specific Guidelines for Child Mental Health Clients, Special Consideration in Assessing Children*, and *Criteria for Level of Eligibility*. For child substance abuse, the document describes the *Child and Adolescent Functional Assessment Scale (CAFAS), Specific Guidelines for Child Substance Abuse*, and *Criteria for Level of Eligibility*.

    This material provides specific behavior descriptions for children including developmental considerations. The material does not provide a clear statement of a strengths-based orientation nor a commitment to family involvement as critical elements of service delivery. The information is specific to one state and geared to its particular forms. This material is not as comprehensive as the *North Carolina Alternatives' Levels of Care*.

Professional Groups and Key Disciplines

24. American Academy of Child and Adolescent Psychiatry. (1996, February). *Level of care placement criteria for psychiatric illness*. Washington, DC: Author, 24 pages.

    These criteria were developed based on national mental health care standards and the clinical consensus and expertise of the child and adolescent psychiatric profession. They are endorsed by the American Association of Children's Residential Treatment Centers, the American Association of Psychiatric Services for Children, the National Association of Social Workers, the Council of Behavioral Group Practices, the American Psychiatric Association, and the National Treatment Consortium. The criteria are a guideline to evaluate medical necessity. The criteria address the following settings because "they are the most frequently utilized": acute inpatient hospitalization, residential treatment, acute partial hospitalization, intensive outpatient, and general outpatient treatment. For each service area, clinical criteria for admission, staffing and service criteria, and criteria for continued stay are included. The criteria address many critical issues in the assessment, treatment, and service delivery for children and adolescents and they provide parameters for medical necessity. However, this is their limitation as well: they are more facility-focused than child-, family-, or community-focused; they do not reflect a holistic view of the child; other important services and supports in the continuum of care are not included; issues related to culture and diversity are not addressed; and service integration issues are minimally dealt with.

25. American Academy of Child and Adolescent Psychiatry Work Group on Quality Issues. (1991, May). Practice parameters for the assessment and treatment of attention-deficit hyperactivity disorder. *Journal of American Academy of Child and Adolescent Psychiatry, 30:3,* 3 pages.

    This document provides practice parameters for the assessment and treatment of attention deficit hyperactivity disorder (ADHD) that were developed by a work group of the American Academy of Child and Adolescent Psychiatry (AACAP) and approved by this organization in 1990. The parameters are segmented for children 3 to 6 and 6 to 12 and highlight in brief outline form some of the basic issues in assessing and treating this complex disorder.

26. American Academy of Child and Adolescent Psychiatry Work Group on Quality Issues. (1992, March). Practice parameters for the assessment and treatment of conduct disorder. *Journal of American Academy of Child and Adolescent Psychiatry, 31:2,* 3 pages.

    These practice parameters for assessing and treating conduct disorders have been developed by a work group of child psychiatrists and approved by the Academy in 1991. They provide a brief and basic outline of some key dimensions in the assessment and treatment of conduct disorders. They reflect critical issues of a strength-based approach; intervention emphasizing family, school and peers; collaboration with other systems; job training and independent living skills; and utilization of community supports and resources. The section on families does not address working with families as partners; the focus is more on the training of parents.

27. Bernstein, G.A. & Shaw, K. (1993, September). Practice parameters for the assessment and treatment of anxiety disorders. *Journal of American Academy of Child and Adolescent Psychiatry, 32:5,* 9 pages.

    These practice parameters, developed by a work group of the Academy, were approved in 1992. This document reviews the literature for child and adolescent anxiety disorders addressing the following dimensions: epidemiology, demographics, the clinical picture, comorbidity, family studies, fears and simple phobias, outcomes treatment, and scientific and clinical ratings. This material provides useful information about anxiety disorders and an outline of assessment and treatment issues from a psychiatric perspective.

28. King, R.R. (1995, October). Practice parameters for the psychiatric assessment of children and adolescents. *Journal of American Academy of Child and Adolescent Psychiatry, 34:10,* 16 pages.

    These practice parameters have been developed by a work group of child psychiatrists and approved by the American Academy of Child and Adolescent Psychiatry (AACAP) in 1995. This document focuses on the unique aspects of conducting a psychiatric assessment of children and adolescents. The document addresses special considerations in the evaluation of children, sources of information including the interview with the parent, a developmental history, a family and community assessment, the interview with the child, the role of standardized instruments, diagnostic formulation, communicating findings and recommendations, and scientific and clinical ratings. While this document reflects the perspective of a more medically-oriented discipline that works with children and adolescents, it provides a comprehensive and useful overview of the assessment process and highlights the need to focus on the strengths of children and families.

29. McClellan, J. & Werry, J. (1994, June). Practice parameters for the assessment and treatment of children and adolescents with schizophrenia. *Journal of American Academy of Child and Adolescent Psychiatry, 33:5*, 19 pages.

    These practice parameters were adopted by the Academy in 1994. The article reviews the literature on children and adolescents with schizophrenia. Since the literature is sparse, information is also drawn from research with adults. The article addresses clinical features of youth with schizophrenia, diagnostic issues including overlap with other disorders, the potential for misdiagnosis, and treatment including antipsychotic medications in conjunction with psychoeducational, psychotherapeutic, and social and educational support programs. Much of the discussion on treatment focuses on issues related to medication.

Managed Behavioral Health Care Industry

Because the materials from managed behavioral health care companies are proprietary, they are only referenced, and their content is not described or summarized.

30. Behavioral Health Network of Vermont, Inc. (1995). *Level of care criteria and guidelines for*

use. Montpelier, VT: Author, 30 pages.

31. Behavioral Health Network of Vermont, Inc. (1995). *Preferred clinical practices guide: Version 2*. Montpelier, VT: Author, 70 pages.

32. CMG Health. (1994). *Clinical management guidelines* (with attached sections). Owings Mill, MD: Author, 98 pages.

33. CNR Health, Inc. (1995, April). *CNR health provider manual.* Table of Contents with the following sections:

    Guidelines for Quality Assessment, Risk Management, Patient Grievances, etc., 8 pages.
    Initiating Outpatient Precertification and Authorization, 30 pages.
    Initiating Inpatient Precertification and Authorization, 36 pages.
    Partial Hospitalization Criteria, 12 pages.
    Provider Checklist, 13 pages.

34. Comprehensive Behavioral Care, Inc. (1996, January). *Inpatient care guidelines: Child and adolescent disorders.* Tampa, FL: Author, 4 pages.

35. Comprehensive Behavioral Care, Inc. (1996, January). *Level of care guidelines: Child and adolescent disorders.* Tampa, FL: Author, 8 pages.

36. Foundation Health PsychCare Services (MHN Division). (1996, February 26). *Clinical services manual*, 128 pages.

37. Green Spring/AdvoCare Materials:

    37(a): AdvoCare, A Subsidiary of Green Spring Health Services, Inc. (1995, July 19). *Provider reference manual.* Nashville, TN: Green Spring Health Services, Inc., 45 pages.

    37(b): Green Spring Health Services, Inc. (1996, February 12). *Application reference guide for Green Spring National Provider Network.* Columbia, MD: Network Development, 9 pages.

    37(c): Green Spring/AdvoCare. (Undated). *Community Mental Health Centers (CMHC) performance standards.* Columbia, MD: Author, 8 pages.

    37(d): Green Spring Health Services, Inc. (Undated). *Meeting the needs of public systems of care: Working together for solutions.* Columbia, MD: AdvoCare Program, 8 pages.

    37(e). Green Spring/AdvoCare. (1996, January 16). *Performance standards for substance abuse agencies*, 15 pages.

37(f): Green Spring Health Services, Inc. (1996, March 5). *Supervised systems of care: The partnership of delegated credentialing.* Columbia, MD: Green Spring Health Services, Inc., 5 pages.

38. Human Affairs International. (1993). *Intensive and primary care management: Mental health and substance abuse,* 100 pages.

39. 39(a): OPTIONS Mental Health. (1992, November 17). *Clinical criteria*. Norfolk, VA: Author, 37 pages.
39(b): OPTIONS Mental Health. (1995, November). *Diagnosis based treatment guidelines* (Rev. ed.). Norfolk, VA: Author, 36 pages.

40. U.S. Behavioral Health. (Undated). *Guidelines for level of care decisions.* Emeryville, CA: Author, 76 pages.

41. Value Behavioral Health. (1995). *The VBH Manual: Clinical protocols and procedures.* Falls Church, VA: Author, 120 pages.

Provider Competencies

This section includes guidance and recommended competencies for the range of professionals working with children and adolescents with mental health problems and their families, for specific disciplines, and for specific practice areas.

General Interdisciplinary Workforce Core Competencies

42. Curtis, L.C. with Burchard, J. & Curtis, M. (1995, October). *System of care workforce competencies for staff serving children and youth experiencing a serious emotional disturbance and their families.* Presented to Center for Mental Health Services, Child, Adolescent, and Family Branch. Burlington, VT: Center for Community Change, Institute for Program Development, Trinity College of Vermont, 69 pages. **[DRAFT ONLY: Do Not Reproduce or Distribute Without CMHS Approval.]**

    This is a monograph produced at the request of the Child, Adolescent and Family Branch of the Center for Mental Health Services. The copy reviewed is a draft dated October 1995. This document reports on the results of a process in which a set of core competencies were developed and reviewed by a broad range of national respondents. The competencies are aimed at administrators, direct service personnel, higher educators, and parent advocates. The document outlines the methodology for determining and reviewing the competencies, a listing of the competencies, and a discussion of their assets and liabilities. An executive summary successfully captures the essence of the work. Appendices include the Stroul and Friedman "Principles of a System of Care," the letter used to request input to the project, a list of respondents who

provided input, the letter used to request review of the competencies developed, a list of the reviewers, and a section on sample reviewer comments.

This is a very powerful document which comprehensively outlines over 160 specific necessary skills under nine basic areas: 1) Respect for children, families community, and culture; 2) Building positive relationships with children, youth, and their families; 3) Working cooperatively and collaboratively with all stakeholders in the design of service plans; 4) Understanding human development and serious emotional disturbance; 5) Understanding of a variety of intervention approaches; 6) Participation in design, delivery, and evaluation of individualized services; 7) Knowledge of service systems; 8) Acting in a professional manner; and 9) Pursue professional growth and development.

This work is an embodiment of the individualized service model within the system of care and is aimed toward system approaches based on wraparound services. The document is comprehensive in outlining the full range of competencies needed to operate successfully within a system of care for children and adolescents with severe emotional disturbance and their families. It is a document derived directly out of the CASSP movement and its philosophies. It points out the breadth of what needs to be considered when approaching training and accountability for or within a system of care.

The document provides a checklist that an administrator, educator, or family advocate could use to make sure that all of the bases are covered as they develop systems, implement services, train, and evaluate their progress. This study makes it clear that the competencies required for the system of care define the system itself.

The discussion within the monograph has foci specifically aimed at several vital constituencies: parent advocates, mental health administrators, and leaders in higher education. For each there is a discussion of application of the competencies as well as its liabilities. This discussion is particularly useful in placing the competencies in context and in understanding how to use them. The document is useful for anyone involved in trying to understand, plan for, receive services within, or implement a system of care.

This study points out its own major gap: it is merely an outline. To fully assure accountability each item needs to be fleshed out. Issues of accountability are focused on assuring appropriate individualized treatment and outcomes. There is a lack of focus on system level accountability, which is important in a managed care environment.

43. Hansen, M., with Anderson, C., Gray, C., Harbaugh, S., Lindblad-Goldberg, S., & Marsh, D. (1996, May 15). *Child, family and community core competencies.* Pennsylvania CASSP Training and Technical Assistance Institute, 80 pages.

This document describes core competencies for professionals who are working with children, teens, and their families and who are working in communities. The core competencies are divided

into three major categories: children, family, and community. The child portion is divided into seven age groups of three years each (0-2, 3-5, 6-8, 9-11, 12-14, 15-17, 18-20), outlining required knowledge and skills for professionals working with each age group. The family portion outlines the requisite knowledge and skills for professionals working effectively with families as partners, and the community portion outlines areas of competency required for effective community-based interagency service delivery.

The material is well-organized, beginning with an introductory section which outlines the core competencies for working in each of the three key areas: children, families, and communities. A numbering system provides a guide to the reader. The required competencies are extensive and reflect well the knowledge and skills needed. Professionals who demonstrate the competencies delineated would indeed be using best practices and be effective in their work. The material offers appropriate topical areas for training such as social and cognitive/language development for each age group.

One area, which could be strengthened, is the dimension of "know thyself" particularly in relation to handling difficult or sensitive situations such as the ability to avoid power struggles with teens or the ability to recognize competitive feelings or behaviors with parents. The role of supervision in addressing these complex areas could enhance the material. Also, for many of these competencies, it would be difficult to measure whether or not a professional possessed the requisite skills, knowledge, attitudes, and/or values.

State Government

See following document cross-referenced under General Interdisciplinary Workforce Core Competencies (Document Number 43):

43. Hansen, M., with Anderson, C., Gray, C., Harbaugh, S., Lindblad-Goldberg, S., & Marsh, D. (1996, May 15). *Child, family and community core competencies.* Pennsylvania CASSP Training and Technical Assistance Institute, 80 pages.

Competencies for Specific Professional Groups/Disciplines

44. American Academy of Child and Adolescent Psychiatry, Department of Clinical Affairs. (1996, February). *Guidelines for training towards community-based systems of care for children with serious emotional disturbances.* Washington, DC: Author, 14 pages.

This document, developed by the Task Force on Community Systems of Care for Children with Serious Emotional Disturbances of the American Academy of Child and Adolescent Psychiatry (AACAP), with partial funding from Robert Wood Johnson Foundation (RWJ) and the Center for Mental Health Services (CMHS), provides guidelines for residency programs to implement educational experiences which offer trainees the competencies required to function effectively in rapidly changing community settings and as tertiary expert consultants in this new environment.

Specific content includes 1) *Characteristics of Community-Based Care* (principles, levels, and roles for child and adolescent psychiatrists); 2) *Guidelines for Child and Adolescent Psychiatry Programs* (knowledge, skills, attitudes, clinical curriculum components, special didactic curriculum component, supervision/mentorship and changes to existing curriculum); and 3) *Evaluation of Curriculum Guidelines.*

This material provides specific recommendations which colleges, universities, departments of mental health, government agencies, and individuals can utilize to delineate competencies needed to function effectively in organized behavioral systems of care. The recommendations highlight the need for a learning environment which incorporates multi-disciplinary collaborations and fit the experience within the context of a community mental health setting, utilizing the hospitals and residential treatment centers as, "integral extensions of community- and family-based, client-centered clinical service system." These are ambitious guidelines to incorporate into an existing psychiatric residency programs. No time frames or priorities are indicated.

45. American Mental Health Counselors Association. (Adopted 1979/1992/1993). *National standards for the clinical mental health counseling* (Rev. ed.). Alexandria, VA: Author, 48 pages.

Contained in this volume are the standards for the clinical practice of mental health counseling and the education and training standards for clinical mental health counselors. They are best categorized as standards and practice/service guidelines. The standards are written from the perspective of the mental health counselor and outline the best practices for mental health counseling.

The standards are identified according to services as opposed to age groups. However, the general nature of the statements make the guidelines appropriate for enhancing services for any age group. The standards emphasize that clinical mental health counselors offer services to couples, families, and groups in order to treat psychopathology and promote optimal mental health. Additional material relating to the provision of appropriate service delivery for children and adolescents and their families would be desirable.

The values of providing high quality services to consumers are implied in some instances and stated in others. For example, the standards concerning confidentiality state that, "trust between clinical mental health counselors and their clients is and essential ingredient of the counseling process." In other areas, such as the service environment, the admonitions to provide consumers with a wholesome environment speak to the value of making consumers comfortable in the surroundings in which the mental health services are offered.

The *Education and Training Standards for Clinical Mental Health Counselors* encompass the knowledge to be mastered in the core curriculum and supervised clinical instruction. Attention to skills is emphasized in the determination of the National Clinical Examination and the Work Sample representing the competency-based criterion as the standard for acquisition of knowledge.

46. American Mental Health Counselors Association. (1987). *AMHCA Code of ethics.* Alexandria, VA: Author, 20 pages.

    The entire *Code of Ethics* and the related *Standards of Practice* for mental health counselors are covered in this publication. The *Code of Ethics* is descriptive and specific in regard to the ethical behavior of counselors. These documents can be best described as a code of ethics with practice and service guidelines identified for each section of the code.

    This material provides guidelines for the professional counselor and the consumer about expected behavior of counselors. It provides a guideline for enhancing the skills and ensuring accountability for those providing counseling services. However, this material is not devoted specifically to children and adolescents. Some interpolation is necessary in order to make it applicable.

47. Clark, S. & Grossman, B. (1992, April). *The California competency-based Child Welfare Curriculum Project report of the Curriculum Sub-Committee of the California Social Work Education Center.* Berkeley, CA: University of California at Berkeley, School of Social Welfare, California Social Work Education Center, 36 pages.

    The purpose of the Child Welfare Social Work Development Project of the California Social Work Education Center was to establish new educational objectives for social workers who work with poor and minority families in publicly-supported child welfare services. Curriculum development in social work education is needed because the field of child welfare is changing rapidly with the current focus on keeping children in their homes and on permanency planning to break the cycle of multiple foster homes for dependent children. Additionally, increased emphasis on recruitment of minority workers and mastery by all workers of skills for culturally competent practice is necessary.

    This report documents the child welfare curriculum development process. The document contains two sections: 1) description of the development process aimed at the improvement of professional competency in child welfare services and 2) the complete competency statement. Six competency categories are defined: a) *Ethnic Sensitive Practice,* b) *Core Child Welfare Skills,* c) *Social Work Skills and Methods,* d) *Human Development and Behavior,* e) *Workplace Management,* and f) *Child Welfare Management*.

    This document identifies critical values, skills, and knowledge to achieve consistent and relevant training for social workers working in child welfare and to reform service delivery for children and families in the child welfare system.

48. National Association of School Psychologists. (1992). *Professional conduct manual: Principles for professional ethics and standards for the provision of school psychological services* (Rev. ed.). Bethesda, MD: Author, 48 pages.

This document establishes both the ethical principles and the standards for professional practice in school psychology. These principles and standards reflect the position of the National Association of School Psychologists (NASP). Part I, *Principles of Professional Ethics,* provides general guidance to practitioners on ethical issues such as professional competency, professional relationships and responsibility, students, and professional practices in public and private settings. Procedural guidelines utilized by NASP for the adjudication of ethical complaints are also included. Part II, *Standards for the Provision of School Psychological Services*, provides a description of services that may be available from most school psychologists. NASP standards are established for the delivery of comprehensive school psychological services for administrative agencies, employing agencies, and professional school psychologists.

This document, when coupled with the *NASP Standards for Training and Field Placement Programs in School Psychology*, provides information on the skills, competencies, and the ethical behaviors expected from professionally-qualified school psychologists. The effectiveness of mental health services for children is dramatically improved when interventions are applied in the natural setting. For children, these natural settings are generally families and schools. This availability of professionals delivering the types of services described in this manual and applying this practice in the natural school setting can serve as a powerful component in a system of comprehensive mental health services for children.

However, the manual must be read in conjunction with a companion document, entitled *NASP Standards for Training and Field Placement Programs in School Psychology* (1994), in order to understand the training skills, competencies, and credentials that school psychologists should possess to qualify them for the provision of the services described in this manual.

49. National Association of School Psychologists. (1994). *Standards: Training programs, field placement program and credentialing standards.* Bethesda, MD: Author, 37 pages.

This document establishes both the standards for training and field placement programs in school psychology and the standards for the credentialing of school psychologists. These standards reflect the position of the National Association of School Psychologists (NASP). Part I, *Standards for Training and Field Placement Programs in School Psychology,* provides the standards that serve as the guide to school psychology graduate education programs for students preparing for careers in school psychology. These standards identify critical course content, training experiences, and performance-based accountability for training programs. These standards also serve as the basis for program evaluation of graduate education programs. Part II, *Standards for the Credentialing of School Psychologists*, provides guidance to credentialing bodies on the requirements, structure, and procedures to be used when implementing credentialing standards. These standards include course work requirements, practica, and internship requirements and define the professional knowledge and competencies that must be demonstrated for the awarding of the credential of school psychologist.

This document provides the foundation of training requirements and standards for the professional practice of school psychology. It is comprehensive, widely used as the standard for graduate level training programs, and provides guidance to credentialing bodies. It also sets the standard for the credential of Nationally Certified School Psychologists (NCSP).

50. National Association of Social Workers. (Undated). *NASW Standards for the practice of social work with adolescents*. Washington, DC: Author, 15 pages.

    These standards for social work practice address the knowledge and skills needed by social workers who work with adolescents to help them deal with their problems. It also contains standards for administrators of youth agencies. The standards represent goals to strive for, as budgets, resources, and personnel shortages often prevent implementation of the standards. Although comprehensive, the standards do not deal with the specialized areas of expertise needed for some adolescents such as those in gangs, substance abusers, and those who are parents. Included in the document are standards relating to understanding adolescent development and family dynamics; empowering adolescents; knowledge of the legal, regulatory, and administrative requirements and resources for youth and their families; maintaining confidentiality; and participating in multidisciplinary case consultation across agencies that provide services to adolescents and their families.

51. National Association of Social Workers. (1981, February 14). *NASW Standards for social work practice in child protection*. Washington, DC: Author, 34 pages.

    This document, approved by the National Association of Social Workers (NASW) at its meeting on February 14, 1981, describes standards for the attainment of competence for all social workers in child protective services (CPS). These standards are further divided into those for the administrator of the CPS agency, the CPS supervisor, the CPS worker, and those social workers employed in settings other than child protective services. Additionally, a taxonomy of standards and a code of ethics are included as well. These standards recognize both the general and specialized aspects of social work that are necessary to alleviate the social, economic, and personal conditions that contribute to child abuse and neglect. The standards are established with the commitment to viewing the family as a dynamic system, seeking new knowledge and refining skills, working with other professionals and community agencies, and supporting needed legislative and institutional change within and outside the CPS system. The goals of the standards are 1) to document the ethics, values, knowledge, and skills of social workers and 2) to establish professional expectations in order to monitor, evaluate, and improve their performance.

    The standards in this document cover generic and specialized knowledge, skills, and values for professional workers and managers in child protective services; they are very detailed and address a wide range of activities performed in both public and private sector agencies. However, the material is dated and, consequently, does not address many of the social issues impacting children and families, such as violence or system reform issues (e.g., permanency planning and building on family strengths).

52. National Association of Social Workers. (1992, June 18). *NASW Standards for school social work services* (Rev. ed.). Washington, DC: Author, 25 pages.

This publication is a revision of the original 1978 *Standards for Social Work Services in School*, which has served as guidelines to the development of school social work. The revised standards are intended to reflect and promote professionally sound practice as well as changing practices and policies. Section I, entitled *Standards of Competence and Professional Practice*, contains 16 standards. Competence is defined as the synthesis of professional behaviors that integrate knowledge, skills, and activities in the performance of tasks of school social work. Professional practice relates to the standards of ethics, provision of services, and responsibilities that school social workers are expected to maintain. Section II, *Standards of Professional Preparation and Development*, relates to the level of training required for school social work practice and contains five standards. Section III, *Standards of Administrative Structure and Support*, contains 12 standards which define adequate administrative structure and support. Three appendices include recommended school social worker to student ratios; knowledge, skills, and abilities areas and dimensions; and a glossary of terms and a code of ethics.

The primary weakness of this publication is that the material revised in 1992 does not reflect the changing environment and move to behavioral health care. In addition, the knowledge, skills, and abilities are quite general and lack sufficient detail to be used, for example, as performance indicators.

See following document cross-referenced under Competencies for Specific Practice Areas (Document Number 53):

53. Rycus, J.S. & Hughes, R.C. (1994). *Child welfare competencies: Promoting family-centered, culturally relevant, and interdisciplinary child welfare practice and training* (2nd ed.). Columbus, OH: Institute for Human Services, 77 pages.

Competencies for Specific Practice Areas

53. Rycus, J.S. & Hughes, R.C. (1994). *Child welfare competencies: Promoting family-centered, culturally relevant, and interdisciplinary child welfare practice and training* (2nd ed.). Columbus, OH: Institute for Human Services, 77 pages.

This document contains standards of practice for child welfare caseworkers, supervisors and managers, foster parents, and juvenile service workers. [According to the document there is also available an *Individual Training Needs Assessment* and computer software for administration and competency-based training system. These latter items were not available for review.] The child welfare competencies are written from the perspective of a public child welfare system. They are very comprehensive and meant to cover the full range of behaviors for competent practice. They are written at a mid-range of abstraction and generally do not address specific behaviors. They

were prepared with the involvement of the child welfare systems in several states and the Child Welfare League of America.

The competencies address child development, cultural competence, child protective services, legal issues, supervision, and foster parenting among other topics. Each section could be used (and, as the introduction suggests, has been used) as the basis for developing more detailed curricula and/or training plans for staff. Accompanying materials indicate that an instrument has been designed as a training needs assessment. This set of standards has the potential to move the child welfare field forward dramatically if every child welfare worker, supervisor, foster parent, and juvenile services worker actually practiced according to these guidelines. Application depends on graduate schools, managed care entities, and others emphasizing and implementing ongoing training, education, and supervision in order to incorporate these competencies into practice. Competencies are also included for specialized areas: adoption, independent living, and culture and diversity. These standards are ambitious but provide a strong foundation.

These competencies lack definition of key concepts such as "family-centered," "cultural competence," and others, although the content implicitly supports and develops some of these ideas. The philosophy/guidelines for practice are not present at this level of abstraction. For example, the section on assessment delineates the principles that workers should be able to identify family strengths and areas of need but does not provide any "how to" information. However, training could be developed to explicate specific learning in each section. It would be difficult to know when someone had mastered each standard. Professional judgments require complex sets of knowledge, skills, attitudes, and behaviors.

In the section addressing competencies for juvenile service workers, adequate attention is not paid to attitudes and self knowledge, which are especially important when the worker is dealing with populations whose personal experience are different. There needs to be greater emphasis on cultural competence, the basis of violence, knowledge about gangs, and other such issues essential for workers to be effective in serving a population of juvenile offenders. Specific techniques and skills are not addressed as thoroughly as necessary to intervene successfully with this growing and difficult population.

Outcome Guides/Studies

This section includes materials developed to provide guidance around establishing and evaluating outcomes of service delivery and treatment interventions for children and adolescents with mental health problems and their families.[2]

54. Nicholson, J. & Robinson, G. (1996, May). *A guide for evaluating consumer satisfaction with child and adolescent mental health services*. Boston, MA: Judge Baker Children's Center, the

[2]The material in this section does not reflect a comprehensive review of the literature on outcomes related to child and adolescent mental health.

Technical Assistance Center for the Evaluation of Children's Mental Health Systems, 66 pages.

This material presents an overview for evaluating consumer satisfaction with child and adolescent mental health services. Included is a review of the "state-of-the-field" in consumer satisfaction, an approach for developing a plan to measure consumer satisfaction, and information on how to select, modify, or create an instrument as well as how to interpret and use the results. An appendix contains a comprehensive description of instruments that address consumer satisfaction with child/adolescent mental health services currently available.

This material is current and well organized, providing both a basic overview of the "state-of-the-art" and a practical "how to" approach in an area that is acknowledged to be in an early development phase. The document acknowledges that 1) it is crucial to solicit the opinion of the recipients of a service in determining if the services are useful, helpful, timely, accessible, and meaningful; 2) there is a lack of a theoretical base for the study of consumer satisfaction with much work needed to be done quickly in this area; 3) consumer satisfaction instruments may not in fact be measuring what families think are important elements of consumer satisfaction; and, 4) consumer satisfaction instruments do not consider cultural and socio-economic differences.

The document's weaknesses include 1) a lack of recognition that consumer evaluation of the performance of service providers can have a significant impact on promoting accountability and quality assurance and 2) little discussion about the importance and use of consumer satisfaction instruments in a managed care environment.

Training Materials and Curricula

This section includes training curricula developed for staff of child-service agencies, for specific service areas, and for specific disciplines.

55. Behar, L. & Zipper, I. (1994). *Case management for children's mental health: A training curriculum for child-serving agencies.* A joint project of the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the University of North Carolina at Chapel Hill, School of Social Work.

    This is a compilation of materials that can be used, in part or as a whole, to guide the development of in-service training workshops for family case managers on topics related to case management and family services.

    This curriculum is a comprehensive approach to training on a variety of content areas related to case management in children's mental health. The 14 modules cover a wide variety of relevant topics. Each module includes learning objectives (the desired outcomes for training); a plan for delivery; the specific points to be addressed; trainer instructions; and masters/originals from which handouts and overhead transparencies can be reproduced. The content is concise, well-organized, and relevant. The main points are listed in bullet form with supporting discussion. References

and resources are provided for further research and development by the trainer, as needed. There is logic and continuity in the sequencing of modules. The curriculum allows the trainer considerable discretion in how to utilize the materials. The curriculum also provides a model related to supervision. Training methods combine presentation with group activities, case examples, and other exercises that develop self-awareness and help trainees master the content being taught.

The curriculum would be most appropriate for practitioners with little to no understanding of what constitutes case management. The curriculum is very strong in developing trainee awareness and knowledge. The majority of the curriculum would be too basic for experienced case managers, particularly those who are familiar with a family-centered, community-based approach. The exceptions might be selected later modules that apply case management to specific service or practice areas (crisis intervention, mental health assessment and intervention, early intervention, and team development). While the curriculum is strong in imparting knowledge and helping trainees understand how such knowledge should be applied in practice, it is less strong in promoting skills development. However, the curriculum provides resources whereby trainers could further expand upon the modules, as desired, to promote skills development. The curriculum would be best used by a skilled trainer with comprehensive knowledge of family-centered services and case management practice. Specific training strategies and activities are not developed to promote transfer to learning.

56. *Child Mental Health Training Curriculum*. (Undated). Columbia, SC: Prepared for the South Carolina Department of Mental Health by the University of South Carolina, College of Social Work, Center for Child and Family Studies.

This material is a comprehensive, multi-disciplinary, child mental health training curriculum intended to increase the knowledge, skills, and leadership capacities of child mental health professionals in South Carolina, specifically in the Department of Mental Health, and improve the quality of care for children with severe emotional disturbances and their families. This training initiative was developed because there is currently no master's or doctoral degree program in the state with an intensive child and adolescent mental health program; as a result, there is a lack of mental health practitioners with expertise in children and adolescents. The training is designed for individuals with a wide variety of educational backgrounds including psychology, social work, child development, and counseling and is guided by the CASSP principles. The themes of training incorporate an approach that is community-based, multi-systemic, family-focused, culturally competent, and strengths-based.

The *Child Mental Health Training Curriculum* (CMHT) has been organized into four volumes. The first volume, *Resources for Child Mental Health Practitioners*, contains materials trainees should review before beginning the classroom training. Three main content areas for the resource book include normative child development, standard child psychopathology, and family systems theory. The second volume contains materials for the first two weeks of classroom training focused on the theoretical aspects of working with children with severe emotional disturbances

and their families including phenomenology and personal construct theory, cultural competence, cognitive and social learning theory, and an overview of family work and community-based mental health services. The second week of training focuses on application and practice highlighting assessment, treatment, and case management. The third and fourth volumes contain materials for the nine follow-up training sessions, which consist of monthly two-day classroom sessions designed to build and elaborate on earlier training levels. Outcome objectives are included in the training.

The CMHT is a comprehensive curriculum that incorporates the principles and values delineated on page 3 and provides an extensive overview of the knowledge base for working with children, adolescents, and their families. While developed for South Carolina, this curriculum has broad applicability and would be useful and relevant for child and adolescent mental health practitioners in other states and communities. The curriculum guide is very detailed in both the session descriptions and content covered, but implementing the training clearly requires highly- skilled trainers who are comfortable with and knowledgeable about the material and content areas referenced. Because of the comprehensiveness and the level of detail, the material is lengthy and difficult to review without going page by page. It would be helpful to have a guide to provide a more concise view of content. (There does not seem to be a table of contents for the CMHT.) Included in the CMHT are major sections that reference documents such as Stroul and Friedman's *System of Care.* This material would benefit greatly from improved packaging.

57. Early, T.J. & Litzelfelner, P. (1992, June). *Crisis intervention with children and adolescents with severe emotional disturbances or mental illness and their families: A training curriculum*. The University of Kansas, School of Social Welfare under contract with South Carolina Department of Mental Health for the Southern Human Resources Development Consortium for Mental Health, 293 pages.

This is a five-day in-service training curriculum. It is designed, "primarily for use by community mental health professionals to be used in home-based work with children and families." This resource was designed as a training resource and has primary utility for this purpose. Its strengths are as follows:

- Curriculum is readable, clearly outlined, well-organized, easy to use. Activities and content are arranged in a logical manner. It is easy to locate materials referenced in the curriculum. Sequential numbering of activities, resource papers, and handouts assists in locating materials.

- The competencies (knowledge and skills) taught in the curriculum are clearly delineated as "learning objectives". The curriculum contains both broad competencies for the curriculum as a whole and more specific competencies for each individual section of the training. The competencies are consistent with and support the normal sequence of learning (developing awareness, knowledge, and understanding prior to addressing application and skill).

- The values underlying the curriculum are clearly stated and presented in trainer instructions, and are given to trainees in handouts.

- The curriculum is well-sequenced. It initially develops trainees' awareness and provides knowledge in topic areas that are prerequisite to crisis counseling, before addressing skill development. It then applies concepts to specific situations - e.g., aggressive and suicidal youth. The sequencing content is generally coherent and logical.

- The curriculum utilizes principles of adult learning throughout. Activities develop relationships, between group members and between group and trainers, prior to beginning the training. Trainees' expectations for the training are elicited early in the training. Experiential learning activities are used throughout the curriculum.

- The curriculum assures that trainees understand the importance of cultural factors, family strengths, and careful listening when providing family services. The curriculum also focuses on concrete and immediate interventions when confronted with families in crisis and then applies concepts to work with aggressive or suicidal youth.

The documents' limitations are as follows:

- The stated intended audience is too broad for best use of the curriculum. While the topic is appropriate for a wide variety of practitioners, the limited depth of the content in this curriculum makes it most appropriate for para-professionals, family service aides, and case managers, who have had little to no prior social work training and whose primary role is to recognize families in or near crisis, to provide interpersonal support, and to refer families for services.

- The content is the weakest part of this otherwise well-developed curriculum. While the topics covered by the curriculum are all very relevant, the curriculum fails to fully develop the content, thereby promoting only a superficial understanding of crisis and its dynamics.

- As the curriculum is currently written, the quality of the training would be largely dependent on the trainers' depth of knowledge and experience in crisis intervention

theory and practice. However, the basic structure is in place. Further development and delineation of content would greatly improve the effectiveness of this curriculum.

APPENDIX A: MEMBERS OF CHILD AND ADOLESCENT PANEL

Chair: Sybil K. Goldman, M.S.W.

National Technical Assistance Center for Children's Mental Health
Georgetown University Child Development Center
3307 M Street, NW, Suite 401
Washington, DC 20007-3935

Paula Armbruster, M.A., M.S.W
Director, Outpatient Services
Yale University Child Study Center
230 S. Frontage Road
New Haven, CT 06510
(203) 785-5930
(203) 737-5455 FAX

Lenore Behar, Ph.D.
Head, Child and Family Services Branch
North Carolina Division of Mental Health, Developmental
Disabilities and Substance Abuse Services
325 North Salisbury Street, Suite 566
Raleigh, NC 27603
(919) 733-0598
(919) 733-8259 FAX

John Burchard, Ph.D.
Professor
Psychology Department
University of Vermont
226 John Dewey Hall
Burlington, VT 05405
(802) 656-2670
(802) 656-8783 FAX

Laurie Curtis
Center for Community Change
Trinity College of Vermont
208 Colchester Avenue
Burlington, VT 05401
(802) 658-0000
(802) 863-6110 FAX

Michael Curtis
Center for Community Change
Trinity College of Vermont
208 Colchester Avenue
Burlington, VT 05401
(802) 658-0000
(802) 863-6110 FAX

Cliff Davis, M.A.
Consultant
10800 Springwater Drive
Mt. Vernon, OH 43050
(614) 397-1915
(614) 397-1916 FAX

Mary Lou deLeon Siantz, Ph.D., R.N., F.A.A.N.
Associate Professor
School of Nursing
Indiana University
1111 Middle Drive NU 4038
Indianapolis, IN 46202-5107
(317) 274-2400
(317) 278-1811 FAX

Mary Jane England, M.D.
Director, Washington Business Group on Health
Robert Wood Johnson Foundation
Mental Health Services Program for
Children's Mental Health
777 North Capitol Street, NE, Suite 800
Washington, DC 20002
(202) 408-9320
(202) 408-9332 FAX

Sandra L. Forquer, Ph.D.
Vice President, OPTIONS Healthcare, Inc.
Executive Director, Colorado Health Networks
201 West 8th Street
Suite 380
Pueblo, CO 80906
(719) 583-7600
(719) 583-7638 FAX

Robert Friedman, Ph.D.
Professor and Chair
Research and Training Center for Children's Mental Health
Florida Mental Health Institute
13301 Bruce B. Downs Boulevard
Tampa, FL 33612-3899
(813) 974-4640
(813) 974-4406 FAX

Barbara Friesen, Ph.D.
Director, Research and Training Center on Family
Support and Children's Mental Health
Portland State University
1912 SW 6th, Room 120
Portland, OR 97207-0751
(503) 725-4166
(503) 725-4180 FAX

Mary Ann Gawelek, Ph.D.
Vice President for Academic Affairs &
Dean of the College
Seton Hill College
Seton Hill Drive
Greensburg, PA 15601
(412) 838-4217

Jerome Hanley, Ph.D.
Division for Children, Adolescents and Their Families
South Carolina Department of Mental Health
2414 Bull Street, Office 304
Columbia, SC 29202
(803) 734-7859
(803) 734-4121 FAX

Sally Hein, Ph.D.
Southern Human Resources Development
Consortium on Mental Health
2414 Bull Street
PO Box 485
Columbia, SC 29202
(803) 734-7898
(803) 734-7897 FAX

Gail Lewis
1048 Rustling Oaks Drive
Millersville, MD 21108
(410) 544-6094 (w)
(410) 544-6094 (h)

Dalia J. Llera, Ed.D.
Assistant Professor
Counseling and Psychology Programs
Lesley College
29 Everett Street
Cambridge, MA 02138
(617) 349-8373
(617) 349-8366 FAX

Ira Lourie, M.D.
Human Service Collaborative
2262 Hall Place, NW
Suite 204
Washington, DC 20007
(202) 333-5998
(202) 333-8217 FAX

Phyllis Magrab, Ph.D.
Director
Center for Child Health & Mental Health Policy
Georgetown University Child Development Center
3307 M Street, NW
Suite 401
Washington, DC 20007
(202) 687-8837
(202) 687-8899 FAX

Maggie Mezera, M.S.
5623 Crestwood Place
Madison, WI 53705
(608) 238-6564

Trina Osher
Federation of Families for Children's Mental Health
1021 Prince St., 2nd Floor
Alexandria, VA 22314-2971
(703) 684-7710
(703) 836-1040 FAX

Andres Pumariega, M.D.
East Tennessee State University
James H. Quillen College of Medicine
Box 70567
Johnson City, TN 36714-0567
(423) 439-6334
(423) 439-7033 FAX

Kathryn K. Rhodes, Ed.S., N.C.C.
Executive Project Coordinator
National Board for Certified Counselors, Inc.
3 Terrace Way
Suite D
Greensborough, NC 27403-3360
(910) 547-0607
(910) 547-0558 FAX

Annette U. Rickel, Ph.D.
3614 Prospect Street, NW
Washington, DC 20007
(202) 338-2562
(202) 338-8394 FAX

Robert Runkel
Administrator, Division of Special Education
Office of Public Instruction
PO Box 202501
1300 11th Avenue
Helena, MT 59620-2501
(406) 444-4429
(406) 444-3924 FAX

Judith Rycus, Ph.D., M.S.W.
Institute for Human Services
1706 East Broad Street
Columbus, OH 43203
(614) 251-6000

Ron Smith
Office of Children's Services Manager
Behavioral Health Services
Arizona Department of Health Services
2122 East Highland
Suite 100
Phoenix, AZ 85016
(602) 381-8998
(602) 553-9143 FAX

APPENDIX B: SELECTED REFERENCES AND BIBLIOGRAPHY

Behar, L. (1992). *Fort Bragg Child and Adolescent Mental Health Demonstration Project.* Raleigh: North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Child and Family Services Branch.

Bickman, L. (1993). *The evaluation of the Fort Bragg demonstration project.* Nashville, TN: Vanderbilt University, Center for Mental Health Policy.

Brandenburg, N., Friedman, R., & Silver, S. (1990). The epidemiology of childhood psychiatric disorders: Prevalence findings from recent studies. *Journal of the American Academy of Child and Adolescent Psychiatry,* 29, 76-83.

Burns, B., & Friedman, R. (1990). Examining the research base for child mental health services and policy. *The Journal of Mental Health Administration,* 17, 87-98.

Cole, R., & Poe, S. (1993). *Partnerships for care--systems of care for children with serious emotional disturbances and their families.* Washington, DC: Washington Business Group on Health, Mental Health Services Program for Youth.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care: Vol. I. A monograph on effective services for minority children who are severely emotionally disturbed.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Davis, M., Yelton, S., & Katz-Leavy, J. (1993). *Unclaimed children revisited: The status of state children's mental health services.* Paper presented to the Sixth Annual Research Conference: A System of Care for Children's Mental Health: Expanding the Research Base, Tampa, FL.

DeChillo, N., Koren, P.E., & Schultz, K.H. (1994). From paternalism to partnership: Family/professional collaboration in children's mental health. *American Journal of Orthopsychiatry,* 64, 564-576.

F r a n k e l , the research. *Social Service Review,* 62(1), 137-157.

Friesen, B.J. (1993). Creating change for children with serious emotional disorders: A n a t i o *Community organization and social* l *administration* (pp. 137-146). New York: The Haworth Press.

Friesen, B.J., Griesbach, J., Jacobs, J.H., Katz-Leavy, J., & Olson, D. (1988). Family support as a central component in the system of care: Improving services for families whose children have serious emotional disorders. *Children Today,* 17(4), 18-22.

Friesen, B.J., & Huff, B. (1990). Parents and professionals as advocacy partners. *Preventing*

School Failure, 34(3), 31-36.

Friesen, B.J., & Koroloff, N.M. (1990). Family-centered services: Implications for mental health administration and research. *Journal of Mental Health Administration*, 17, 13-25.

Goldman, S. (1988). *Series on community-based services for children and adolescentswho are severely emotionally disturbed: Vol. II. Crisis services.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Institute of Medicine. (1989). *Research on children and adolescents with mental, behavioral, & developmental disorders.* Washington, DC: National Academy Press.

Isaacs, M. (1993). Developing culturally competent strategies for adolescents of color. In A. Elster, S. Panzarine, & K. Holt (Eds.), *Adolescent health promotion (State-of-the-art conference)* (pp. 35-54). Chicago: American Medical Association.

Isaacs, M., & Benjamin, M. (1992). *Towards a culturally competent system of care: Vol. II. Programs which utilize culturally competent principles.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Joint Commission on the Mental Health of Children. (1969). *Crisis in child mental health.* New York: Harper & Row.

Katz-Leavy, J., Lourie, I., Stroul, B., & Zeigler-Dendy, C. (1992). *Individualized services in a system of care.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services.* Washington, DC: Children's Defense Fund.

Kravitz, S. (1991). Professional social work education and public child welfare: Where do we stand? Where are we going? *Future Choices*, 3(1).

Kutash, K., & Rivera, V. (1996). *What works in children's mental health services? Uncovering answers to critical questions.* Baltimore, MD: Paul H. Brookes.

National Institute of Mental Health. (1990). *National plan for research on child and adolescents mental disorders.* Rockville, MD: U.S. Department of Health and Human Services.

National Mental Health Association. (1989). *Invisible children project: Resource kit.* Alexandria, VA: author.

Pires, S., Stroul, B., Roebuck, L., Friedman, R., McDonald, B., & Chambers, K. (1995). *Health care reform tracking project: The 1995 state survey.* Tampa, FL: Research and Training Center for Children's Mental Health, Florida Mental Health Institute.

Pires, S.A. (1992). *Staffing systems of care for children and families: A report of the Southern Human Resource Development Consortium for Mental Health on Workforce Issues Related to Community-Based Service Delivery for Children and Adolescents with Serious Emotional Disturbances/Mental Illness and Their Families.* Washington, DC: Human Service Collaborative.

President's Commission on Mental Health. (1978). *Report of the sub-task panel on infants, children, and adolescents.* Washington, DC: Author.

Stroul, B. (Ed.) (1996). *Children's mental health: Creating systems of care in a changing society.* Baltimore, MD: Paul H. Brookes.

Stroul, B. (1995). *Managed care and children's mental health: Summary of the May 1995 state managed care meeting.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Stroul, B. (1993). *System of care for children and adolescents with severe mental disturbances. What are the results?* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Stroul, B. (1989). *Series on community-based services for children and adolescents who are severely emotionally disturbed: Vol. III. Therapeutic foster care.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Stroul, B. (1988). *Series on community-based services for children and adolescents who are severely emotionally disturbed: Vol. I. Home-based services.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Stroul, B., & Friedman, R. (1986/1994). *A system of care for children and youth with severe emotional disturbances (Rev. ed.).* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Stroul, B., Lourie, I., Goldman, S., & Katz-Leavy, J. (1992). *Profiles of local systems of care for children and adolescents with severe emotional disturbances.* Washington, D.C.: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Stroul, B., McCormack, M., & Zaro, S. (1996). Measuring outcomes in systems of care. In *Children's mental health: Creating systems of care in a changing society*. Baltimore, MD: Paul H. Brooks, pp. 313-337.

Stroul, B., Pires, S., Katz-Leavy, J., & Goldman, S. (1994). Implications of the Health Security Act for mental health services for children and adolescents. *Hospital and Community Psychiatry*, 459, 887-882.

U.S. Congress, Office of Technology Assessment. (1986). *Children's mental health: Problems and services--a background paper*. Washington, DC: Author.

VanDenBerg, J.E. (1992). Individualized services for children. In E. Peschel, R. Peschel, C.W. Howe, & J.W. Howe (Eds.), *Neurobiological disorders in children, New directions for mental health services* (no. 54, pp. 97-100). San Francisco: Jossey-Bass.

VanDenBerg, J.E. (1993). Integration of individualized mental health services into the system of care for children and adolescents. *Administration and Policy in Mental Health*, 20, 247-257.

APPENDIX C: BIBLIOGRAPHY OF MATERIALS REVIEWED AND INFORMATION ON HOW TO OBTAIN

AdvoCare, A Subsidiary of Green Spring Health Services, Inc. (1995, July 19). *Provider reference manual.* Nashville, TN: Green Spring Health Services, Inc., 45 pages.

AdvoCare, 222 Second Ave., North, Suite 220, Nashville, TN 37201; 1-800-325-7868, FAX: (615) 313-4481

American Academy of Child and Adolescent Psychiatry Work Group on Quality Issues. (1991, May). Practice parameters for the assessment and treatment of attention-deficit hyperactivity disorder. *Journal of American Academy of Child and Adolescent Psychiatry, 30:3*, 3 pages.

AACAP, 3615 Wisconsin Ave., NW, Washington, DC 20016; (202) 966-7300

American Academy of Child and Adolescent Psychiatry Work Group on Quality Issues. (1992, March). Practice parameters for the assessment and treatment of conduct disorder. *Journal of American Academy of Child and Adolescent Psychiatry, 31:2*, 3 pages.

AACAP, 3615 Wisconsin Ave., NW, Washington, DC 20016; (202) 966-7300

American Academy of Child and Adolescent Psychiatry. (1996, February). *Best principles for managed care Medicaid RFP's: How decision-makers can select and monitor high quality programs!* Washington, DC: Author, 21 pages.

AACAP, 3615 Wisconsin Ave., NW, Washington, DC 20016; (202) 966-7300

American Academy of Child and Adolescent Psychiatry, Department of Clinical Affairs. (1996, February). *Guidelines for training towards community-based systems of care for children with serious emotional disturbances.* Washington, DC: Author, 14 pages.

AACAP, 3615 Wisconsin Ave., NW, Washington, DC 20016; (202) 966-7300

American Academy of Child and Adolescent Psychiatry. (1996, February). *Level of care placement criteria for psychiatric illness.* Washington, DC: Author, 24 pages.

AACAP, 3615 Wisconsin Ave., NW, Washington, DC 20016; (202) 966-7300

American Managed Behavioral Healthcare Association . (1995, August). *Performance measures for managed behavioral healthcare programs.* Washington, DC: Author, 27 pages.

AMBHA, 700 Thirteenth St., NW, Suite 950, Washington, DC 20005; (202) 434-4565, FAX: (202) 434-4564

American Mental Health Counselors Association. (Adopted 1979/1992/1993). *National standards for the clinical mental health counseling* (Rev. ed.). Alexandria, VA: Author, 48 pages.

AMHCA, P.O. Drawer 22370, Alexandria, VA 22304; (703) 823-9800, Ext. 383, 1-800-326-2642, FAX: (703) 751-1696

American Mental Health Counselors Association. (1987). *AMHCA Code of ethics.* Alexandria, VA: Author, 20 pages.

AMHCA, P.O. Drawer 22370, Alexandria, VA 22304; (703) 823-9800, Ext. 383, 1-800-326-2642, FAX: (703) 751-1696

Bazelon Center for Mental Health Law & the Federation of Families for Children's Mental Health. (1996). *A family advocate's guide: Managed behavioral health care for children and youth.* Washington, DC: Bazelon Center for Mental Health Law.

Publications Desk, Bazelon Center for Mental Health Law, 1101 15th St., NW, #1212, Washington, DC 20005; (202) 467-5730; FAX: (202) 223-0409; E-mail: hn1660@handsnet.org; Website: http://www.bazelon.org/bazelon

Bazelon Center for Mental Health Law & the Federation of Families for Children's Mental Health. (1996). *Your family and managed care: A guide for families of children with mental, emotional, or behavioral disorders.* Washington, DC: Bazelon Center for Mental Health Law.

Publications Desk, Bazelon Center for Mental Health Law, 1101 15th St., NW, #1212, Washington, DC 20005; (202) 467-5730; FAX: (202) 223-0409; E-mail: hn1660@handsnet.org; Website: http://www.bazelon.org/bazelon

Behar, L. & Zipper, I. (1994). *Case management for children's mental health: A training curriculum for child-serving agencies.* A joint project of the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the University of North Carolina at Chapel Hill, School of Social Work.

NC Division of Mental Health, Developmental Disabilities & Substance Abuse Services, Dept. of Human Resources, 325 N. Salisbury St., Raleigh, NC 27603; (919) 733-0598, FAX: (919) 733-8259

Behavioral Health Network of Vermont, Inc. (1995). *Level of care criteria and guidelines for use*. Montpelier, VT: Author, 30 pages.

BHN of Vermont, P.O. Box 585-1277, Montpelier, VT 05601; (802) 229-1225, FAX: (802) 229-4606

Behavioral Health Network of Vermont, Inc. (1995). *Preferred clinical practices guide: Version 2*. Montpelier, VT: Author, 70 pages.

BHN of Vermont, P.O. Box 585-1277, Montpelier, VT 05601; (802) 229-1225, FAX: (802) 229-4606

Bernstein, G.A. & Shaw, K. (1993, September). Practice parameters for the assessment and treatment of anxiety disorders. *Journal of American Academy of Child and Adolescent Psychiatry, 32:5*, 9 pages.

AACAP, 3615 Wisconsin Ave., NW, Washington, DC 200016; (202) 966-7300

Center for Mental Health Services. (Undated). *Principles for system of managed care.* [Brochure]. Rockville, MD: Author, 2 pages.

CMHS Knowledge Exchange Network (KEN): 1-800-789-CMHS (2647)

Child Mental Health Training Curriculum. (Undated). Columbia, SC: Prepared for the South Carolina Department of Mental Health by the University of South Carolina, College of Social Work, Center for Child and Family Studies.

Southern HRD Consortium, 2414 Bull St., Columbia, SC 29202

Clark, S. & Grossman, B. (1992, April). *The California competency-based Child Welfare Curriculum Project report of the Curriculum Sub-Committee of the California Social Work Education Center*. Berkeley, CA: University of California at Berkeley, School of Social Welfare, California Social Work Education Center, 36 pages.

University of California at Berkeley, School of Social Welfare, California Social Work Education Center, Berkeley, CA

CMG Health. (1994). *Clinical management guidelines* (with attached sections). Owings Mill, MD: Author, 98 pages.

CMG Health, 25 Crossroads Dr., Owings Mills, MD 21117; (410) 581-5000

CNR Health, Inc. (1995, April). *CNR health provider manual.* [Table of Contents with attached sections].

CNR Health, Inc., 2514 S. 102nd St., Milwaukee, WI 53227; Provider Relations Dept.: (414) 327-5197 or 1-800-654-5160

Commonwealth of Massachusetts, Department of Mental Health. (Multiple dates). *Standards, clinical criteria, practice guidelines*. [Multiple material, different dates].

Dept. of Mental Health, 160 N. Washington St., Boston, MA (no zip code)

Comprehensive Behavioral Care, Inc. (1996, January). *Inpatient care guidelines: Child and adolescent disorders.* Tampa, FL: Author, 4 pages.

Comprehensive Behavioral Care, 4200 W. Cypress St., Suite 300, Tampa, FL 33607; (813) 876-5036 or 1-800-382-3259, FAX: (813) 872-8666

Comprehensive Behavioral Care, Inc. (1996, January). *Level of care guidelines: Child and adolescent disorders.* Tampa, FL: Author, 8 pages.

Comprehensive Behavioral Care, 4200 W. Cypress St., Suite 300, Tampa, FL 33607; (813) 876-5036 or 1-800-382-3259, FAX: (813) 872-8666

Consumer-oriented mental health report card: The final report of the Mental Health Statistics Improvement Program (MHSIP) task force on a consumer-oriented mental health report card. (1996, April). A collaborative effort of the MHSIP community and the Center for Mental Health Services, 145 pages.

CMHS Knowledge Exchange Network: 1-800-789-CMHS (2647)

Council on Accreditation. (Review copy, to be published 1997). *COA draft revised standards - Volume I: Behavioral healthcare standards and Volume II: Community support and education services.* [In disk format]. New York: Author.

COA, 448 W. 16th St., New York, NY 10011

Curtis, L.C. with Burchard, J., & Curtis, M. (1995, October). *System of care workforce competencies for staff serving children and youth experiencing a serious emotional disturbance and their families.* Presented to Center for Mental Health Services, Child, Adolescent, and Family Branch. Burlington, VT: Center for Community Change, Institute for Program Development, Trinity College of Vermont, 69 pages.

Center for Community Change, Inst. for Program Development, Trinity College of Vermont, 208 Colchester Ave., Burlington, VT 05401. **[DRAFT ONLY: Do Not Reproduce or Distribute Without CMHS Approval.]**

Early, T.J. & Litzelfelner, P. (1992, June). *Crisis intervention with children and adolescents with severe emotional disturbances or mental illness and their families: A training curriculum*. The University of Kansas, School of Social Welfare under contract with South Carolina Department of Mental Health for the Southern Human Resources Development Consortium for Mental Health, 293 pages.

Southern HRD Consortium, 2414 Bull St., Columbia, SC 29202

Federation of Families for Children's Mental Health. (1995, July 7). *Principles of family involvement in the development and operation of managed health and mental health systems for children and youth*, 3 pages.

Federation of Families of Children's Mental Health, 1021 Prince St., 2nd Floor, Alexandria, VA 22314-2971; (703) 684-7710, FAX: (703) 836-1040

Foundation Health PsychCare Services (MHN Division). (1996, February 26). *Clinical services manual*, 128 pages.

Contact person: Gregory Miller; no address given.

Green Spring/AdvoCare. (1996, January 16). *Performance standards for substance abuse agencies*, 15 pages.

Network Development, P.O. Box 3100, Columbia, MD 21045-7100; 1-800-788-4005, FAX: (410) 740-0475

Green Spring Health Services, Inc. (1996, February 12). *Application reference guide for Green Spring National Provider Network.* Columbia, MD: Network Development, 9 pages.

Network Development, P.O. Box 3100, Columbia, MD 21045-7100; 1-800-788-4005, FAX: (410) 740-0475

Green Spring Health Services, Inc. (1996, March 5). *Supervised systems of care: The partnership of delegated credentialing.* Columbia, MD: Green Spring Health Services, Inc., 5 pages.

Network Development, P.O. Box 3100, Columbia, MD 21045-7100; 1-800-788-4005, FAX: (410) 740-0475

Green Spring/AdvoCare. (Undated). *Community Mental Health Centers (CMHC) performance standards.* Columbia, MD: Author, 8 pages.

Network Development, P.O. Box 3100, Columbia, MD 21045-7100; 1-800-788-4005, FAX: (410) 740-0475

Green Spring Health Services, Inc. (Undated). *Meeting the needs of public systems of care: Working together for solutions.* Columbia, MD: AdvoCare Program, 8 pages.

Network Development, P.O. Box 3100, Columbia, MD 21045-7100; 1-800-788-4005, FAX: (410) 740-0475

Hansen, M., with Anderson, C., Gray, C., Harbaugh, S., Lindblad-Goldberg, S., & Marsh, D. (1996, May 15). *Child, family and community core competencies.* Pennsylvania CASSP Training and Technical Assistance Institute, 80 pages.

Pennsylvania CASSP Institute, 2001 North Front St., Suite 316, Harrisburg, PA 17102, (717) 232-3125, FAX: (717) 232-4597

Human Affairs International. (1993). *Intensive and primary care management: Mental health and substance abuse,* 100 pages.

HAI, Clinical Policies & Programs, 488 East 6400 South, Suite 300, Salt Lake City, UT 84107; (801) 578-7364, FAX: (801) 578-7666

Joint Commission on Accreditation of Healthcare Organizations. (1994). *1995 MHM: Accreditation manual for mental health, chemical dependency, and mental retardation/ developmental disabilities services, Volume 1: Standards*. Oakbrook Terrace, IL: Author, 162 pages.

JCAHO, One Renaissance Blvd., Oakbrook Terrace, IL 60181; Customer Service: (708) 916-5800

Joint Commission on Accreditation of Healthcare Organizations. (1995). *1996 Comprehensive accreditation manual for health care networks (CAMHCN)*. Oakbrook Terrace, IL: Author.

JCAHO, One Renaissance Blvd., Oakbrook Terrace, IL 60181; Customer Service: (708) 916-5800

King, R.R. (1995, October). Practice parameters for the psychiatric assessment of children and adolescents. *Journal of American Academy of Child and Adolescent Psychiatry, 34:10,* 16 pages.

AACAP, 3615 Wisconsin Ave., NW, Washington, DC 200016; (202) 966-7300

Malloy, M. (1995, April). *Mental illness and managed care: A primer for families and consumers.* Arlington, VA: National Alliance for the Mentally Ill, 80 pages.

NAMI, 200 N. Glebe Rd., Suite 1015, Arlington, VA, 22203-3754

McClellan, J. & Werry, J. (1994, June). Practice parameters for the assessment and treatment of children and adolescents with schizophrenia. *Journal of American Academy of Child and Adolescent Psychiatry, 33:5,* 19 pages.

AACAP, 3615 Wisconsin Ave., NW, Washington, DC 200016; (202) 966-7300

National Association of School Psychologists. (1992). *Professional conduct manual: Principles for professional ethics and standards for the provision of school psychological services* (Rev. ed.). Bethesda, MD: Author, 48 pages.

NASP Publications, 4340 East West Highway, Suite 402, Bethesda, MD 20814

National Association of School Psychologists. (1994). *Standards: Training programs, field placement program and credentialing standards.* Bethesda, MD: Author, 37 pages.

NASP Publications, 4340 East West Highway, Suite 402, Bethesda, MD 20814

National Association of Social Workers. (1981, February 14). *NASW Standards for social work practice in child protection*. Washington, DC: Author, 34 pages.

NASW, 750 First Street, NE, Suite 700, Washington, DC 20002; Fax: (202) 336-8310

National Association of Social Workers. (1992, June 18). *NASW Standards for school social work services* (Rev. ed.). Washington, DC: Author, 25 pages.

NASW, 750 First Street, NE, Suite 700, Washington, DC 20002; Fax: (202) 336-8310

National Association of Social Workers, National Council on the Practice of Clinical Social Work. (1993, June). *The social work perspective on managed care for mental health and substance abuse treatment.* Washington, DC: National Association of Social Workers, 12 pages.

NASW, 750 First Street, NE, Suite 700, Washington, DC 20002; Fax: (202) 336-8310

National Association of Social Workers. (Undated). *NASW Standards for the practice of social work with adolescents*. Washington, DC: Author, 15 pages.

NASW, 750 First Street, NE, Suite 700, Washington, DC 20002; Fax: (202) 336-8310

National Committee for Quality Assurance (NCQA). (1996, April 1). *Draft accreditation standards for managed behavioral healthcare organizations.* Washington, DC: Author, 83 pages.

NCQA, 2000 L St., NW, Suite 500, Washington, DC 20036; (202) 955-3500, FAX: (202) 955-3599; http://www.ncqa.com

Nicholson, J. & Robinson, G. (1996, May). *A guide for evaluating consumer satisfaction with child and adolescent mental health services*. Boston, MA: Judge Baker Children's Center, the Technical Assistance Center for the Evaluation of Children's Mental Health Systems, 66 pages.

The T.A. Center for the Evaluation of Children Mental Health Systems, Judge Baker Children's Center, 295 Longwood Ave., Boston, MA 02115; (617) 232-8390, FAX: (617) 232-4125

North Carolina. (1993, July 26/1993, December 6). *Cardinal Child and Adolescent Mental Health Service System criteria to be used as guidance in determining levels of care*, 13 pages.

NC Division of Mental Health, Developmental Disabilities & Substance Abuse Services, Dept. of Human Resources, 325 N. Salisbury St., Raleigh, NC 27603; (919) 733-0598, FAX: (919) 733-8259

North Carolina. (1995, November 27). *Levels of care for psychiatric and substance abuse diagnosis (children)*. Prepared for Carolina Alternatives Managed Care Work Group, 24 pages.

NC Division of Mental Health, Developmental Disabilities & Substance Abuse Services, Dept. of Human Resources, 325 N. Salisbury St., Raleigh, NC 27603; (919) 733-0598, FAX: (919) 733-8259

OPTIONS Mental Health. (1992, November 17). *Clinical criteria*. Norfolk, VA: Author, 37 pages.

OPTIONS, 240 Corporate Blvd., Norfolk, VA 23502; (804) 459-5200 or 1-800-451-3581

OPTIONS Mental Health. (1995, November). *Diagnosis based treatment guidelines* (Rev. ed.). Norfolk, VA: Author, 36 pages.

OPTIONS, 240 Corporate Blvd., Norfolk, VA 23502; (804) 459-5200 or 1-800-451-3581

Rycus, J.S. & Hughes, R.C. (1994). *Child welfare competencies: Promoting family-centered, culturally relevant, and interdisciplinary child welfare practice and training* (2nd ed.). Columbus, OH: Institute for Human Services, 77 pages.

Institute for Human Services, 1706 East Broad St., Columbus, OH 43203, (614) 251-6000

Science Applications International Corporation. (1995, November). *Mental health quality monitoring screens and utilization review criteria.* Project funded by the Department of Defense, Health Affairs, 262 pages.

SAIC National Quality Monitoring Program, 10074 SW Arctic Drive, Beaverton, OR 97005; (503) 643-3755

State Mental Health Representatives for Children and Youth. (1995, July 14, Draft). *Successful integration of system of care development with managed behavioral healthcare technologies in public children's mental health*. Alexandria, VA: Author, 11 pages.

SMHRCY, 66 Canal Center Plaza, Suite 302, Alexandria, VA 22314; (703) 739-9333, FAX: (703) 548-9517

State of Delaware, Department of Services for Children, Youth and their Families, Division of Child Mental Health Services. (1994, May). *Standards for professional practice and directions for data collection: Outpatient mental health services, outpatient substance abuse treatment services,* 70 pages.

State of Delaware, Department of Services for Children, Youth and their Families, Division of Child Mental Health Services, Delaware Youth and Family Center, Center & Faulkland Roads, Wilmington, DE 19805-1195; (302) 633-2600, FAX: (302) 633-2614

State of Delaware, Department of Services for Children, Youth and their Families, Division of Child Mental Health Services. (1995, August 22). *Draft: Mental health services for children and adolescents criteria for hospitalization,* 5 pages.

State of Delaware, Department of Services for Children, Youth and their Families, Division of Child Mental Health Services, Delaware Youth and Family Center, Center & Faulkland Roads, Wilmington, DE 19805-1195; (302) 633-2600, FAX: (302) 633-2614

State of Delaware, Division of Mental Health Services, the Department of Services for Children, Youth, and Their Families. (Undated). *Standards: Quality improvement program*. Series A, Vol. 1, 20 pages.

State of Delaware, Department of Services for Children, Youth and their Families, Division of Child Mental Health Services, Delaware Youth and Family Center, Center & Faulkland Roads, Wilmington, DE 19805-1195; (302) 633-2600, FAX: (302) 633-2614

State of New Mexico, Children, Youth and Families Department, Office of Managed Care Services. (1995, August 29). *Certification standards for children and adolescent mental health services*, 68 pages.

P.O. Box Drawer 5160, Santa Fe, NM, 87502-5160

Stelle, L.E. (Undated). *Level of eligibility for child mental health and substance abuse services.* Division of Mental Health/Developmental Disabilities/Substance Abuse, North Carolina Department of Human Resources, 17 pages.

NC Division of Mental Health, Developmental Disabilities & Substance Abuse Services, Dept. of Human Resources, 325 N. Salisbury St., Raleigh, NC 27603; (919) 733-0598, FAX: (919) 733-8259

U.S. Behavioral Health. (Undated). *Guidelines for level of care decisions.* Emeryville, CA: Author, 76 pages.

USBH, 2000 Powell St., Suite 1180, Emeryville, CA 94608-1832; (510) 601-2200

Value Behavioral Health. (1995). *The VBH Manual: Clinical protocols and procedures.* Falls Church, VA: Author, 120 pages.

VBH, 3110 Fairview Park Dr., Falls Church, VA 22042