

## **Community-Based Systems Approach to Children's Managed Mental Health Services**

**Andres J. Pumariega, M.D.,<sup>1,13</sup> David Nace, M.D.,<sup>2</sup> Mary Jane England, M.D.,<sup>3</sup> John Diamond, M.D.,<sup>4</sup> Theodore Fallon, M.D., M.P.H.,<sup>5</sup> Graeme Hanson, M.D.,<sup>6</sup> Ira Lourie, M.D.,<sup>7</sup> Larry Marx, M.D.,<sup>8</sup> Albert Solnit, M.D.,<sup>9</sup> Catherine Grimes, M.D.,<sup>10</sup> Deborah Thurber, M.D.,<sup>11</sup> and Mary Graham, B.A.<sup>12</sup>**

The increasing implementation of managed care principles in the organization and financing of mental health services has now entered the area of children's mental health services, especially as states seek to control the increasing costs of Medicaid programs. Managed care approaches are relatively new in mental health and those that exist have been developed with adult and private sector populations in mind. If applied to child mental health services, the usual benefits restriction approach in traditional behavioral managed care has the potential of depriving children of timely and effective intervention and prevention services. This movement to managed

<sup>1</sup>Professor and Chair, Department of Psychiatry, East Tennessee State University, Johnson City, TN.

<sup>2</sup>Vice President, Health Affairs International, Salt Lake City, UT.

<sup>3</sup>President, Washington Business Group on Health, Washington, DC.

<sup>4</sup>Associate Professor and Director of Child Psychiatry Residency, East Carolina School of Medicine, Greenville, NC.

<sup>5</sup>Assistant Professor and Director of Emergency Psychiatry, Allegheny University Hospitals, Philadelphia, PA.

<sup>6</sup>Associate Professor and Director of Child Psychiatry Residency, University of California-San Francisco, San Francisco, CA.

<sup>7</sup>Consultant, Human Service Collaborative, Alexandria, VA.

<sup>8</sup>Director, Aurora Behavioral Health Services, Wauwatosa, WI.

<sup>9</sup>Sterling Professor of Child Psychiatry, Yale Child Study Center, New Haven and Commissioner of Mental Health, State of Connecticut, CT.

<sup>10</sup>Medical Director, Center for Mental Health, Harvard Community Plan, Boston, MA.

<sup>11</sup>Private Practice of Child and Adolescent Psychiatry, Seattle, WA.

<sup>12</sup>Director, Office of Health Financing, American Psychiatric Association, Washington, DC.

<sup>13</sup>Correspondence should be directed to Andres J. Pumariega, East Tennessee State University, P.O. Box 70567, Johnson City, TN 37614.

behavioral health services necessitated the application of community-based systems of care principles in these managed services so as to ensure that the needs of seriously emotionally disturbed children are met within the imperatives of cost containment. In order to promote the implementation of these principles in publically funded managed behavioral services, the Task Force on Community-Based Systems of Care of the American Academy of Child and Adolescent Psychiatry has developed guidelines for the implementation of managed Medicaid contracts by states and other governmental entities. We review these guidelines and provide the historical background of the development of the community-based systems of care approach to child mental health services.

## INTRODUCTION

The increasing implementation of managed care principles in the organization and financing of mental health services has now entered the area of children's mental health services. This is even more evident as states and governmental entities seek to control the increasing costs of Medicaid programs. Medicaid, the public insurance program for the poor and disabled, funds a significant proportion of child mental health services in the United States, both through the coverage of AFDC recipients as well as through its coverage of children with disabilities. Approximately 14% of children and adolescents 18 and under are enrolled in the Medicaid program, with at least 450,000 of them having severe emotional disturbances (Fox & Wicks, 1995). The great majority of these children and youth are poor, underserved children of ethnic minority backgrounds, with Medicaid being their only health insurance resource.

However, managed care approaches are relatively new in mental health, and those that exist have been developed with adult and private sector populations in mind. These approaches have relied on a priori benefit restrictions based on actuarial data on services utilization, but data which averages in both severely and chronically ill individuals which are high utilizers of services with large pools of relatively healthy, minimally impaired low utilizers. Children covered under Medicaid as a rule suffer from multiple psychosocial stressors, including poverty, discrimination, stresses from acculturation and cultural adaptation, pressures towards substance abuse, as well as the weakening of their families and support systems from the impact of these stressors. Their complex needs often require more intensive and more closely coordinated medical and mental health services, as well as services offered by multiple child services agencies such as education, child welfare, and juvenile justice. If applied to child mental health services,

the usual benefits restriction approach in traditional behavioral managed care has the potential of depriving children of timely and effective intervention and prevention services. This results in fragmentation of care and the shifting of the burden of services and cost to the other child serving agencies and systems and potential for significantly increased morbidity (increased drug abuse, school drop-out, child abuse, teen pregnancy, homelessness) and even mortality (teen suicide, homicide, and accidental death; Snowden, 1993). Managed care models for children's mental health need to emphasize prevention of such morbidity through enhancing family and community resources and reducing psychosocial stressors for the child as they provide clinical services.

### **DEVELOPMENT OF THE COMMUNITY-BASED SYSTEMS APPROACH**

The community-based systems approach has been in place since the earliest origins of child mental health services. These services in fact began in the United States in response to the perceived need for counseling juvenile offenders rather than incarcerating them with adult offenders. This was the case in the 1890's, when America was also undergoing rapid cultural changes due to immigration as well as rapid industrialization and urbanization. These social strains also resulted at that time in marked increases in crime committed by juveniles. Enlightened reformers saw the need for detaining young offenders separately from adult prisoners, adjudicating them in a separate court system (thus the beginning of the juvenile courts), and providing rehabilitative services to them. The juvenile court clinics in Chicago and Boston gave rise to the first child mental health services in the nation. The success of these clinics led the Commonwealth Foundation to commission a study which recommended the development of child guidance clinics throughout the United States and that these be staffed with interdisciplinary teams of professionals which could serve the child and the family. These clinics at first were primarily staffed by social workers, but later attracted pediatricians, psychologists, psychoanalysts, and psychiatrists, and later served as the bases of the first child psychiatry programs in the nation. These clinics were quite removed from the specialty-driven medical system which was evolving in tertiary medical centers, and particularly apart from the practice of hospital-bound care. They provided low-cost services oriented to the needs of the child and the family, with treatment modalities evolving to include individual psychodynamic psychotherapy, family therapy, crisis intervention, and even day treatment programs. Many have survived to this day have served as the core for the



child mental health services in many community mental health centers (Berlin, 1991).

The move towards the medicalization of psychiatry served to move child and adolescent mental health services towards a more hospital-based, tertiary care model. This left the child guidance clinics and the community mental health centers which followed them without significant psychiatric input as well as generally understaffed and underfunded, neglecting the development of children's services. In the meantime, the United States experienced an explosion in the population of poor, minority children which needed significant mental health services but could not access them easily, leading to increasing morbidity amongst them. Many of these children came into the custody of child service agencies due to their parents' inability to care for them in their home environments and went on to be cared for in residential and detention facilities. In the meantime, the use of hospital-level care for the psychiatric treatment of children and adolescents increased exponentially throughout the late 1970s and 1980s, leading to spiraling costs for private and public insurers alike.

The modern era of community-based systems of care was ushered by the publication of Jane Knitzer's groundbreaking book, *Unclaimed Children*, in 1982, which exposed the above listed consequences of neglecting the provision of community-based mental health services for children and their families. Her advocacy as well as that of others led to the development of such services led to the development of the Child and Adolescent Service System Program (CASSP), which, under the leadership of Ira Lourie, M.D. (Lourie & Katz-Leavy, 1986), assisted all 50 states in the development of an infrastructure for publically funded community-based services. The CASSP initiative was supported by the conceptual work of Stroul and Friedman (1986), who, in coining the term "community-based system of care for seriously emotionally disturbed children," advocated interagency coordination amongst all of the child service agencies in the provision of mental health services for children and related family support services. They also proposed that such services be delivered as close to the child's home and community as possible, averting the use of more restrictive levels of care which often served to separate children from their natural family and community supports. The work of Hobbs (1976) in the development of the "Re-Ed" model of supportive/educational approaches with children with emotional disturbances and that of Friesen and Koroloff (1990) extended this concept to involve families not just as the subjects of intervention, but as partners in the effective treatment for the child.

The emerging community-based systems of care model was introduced and tested over the past five years by a number of funding programs and in a number of sites. Over 20 pilot community programs funded by the

Center for Mental Health Services in the past five years and based in states and communities with strong child mental health services infrastructures. The Robert Wood Johnson Foundation, following the leadership of Dr. Mary Jane England (England & Cole, 1992), developed and funded eight community-based systems model demonstration sites which utilized existing community-based services and agencies, organized them into networks with access to flexible funding for services for seriously emotionally disturbed children, and used actuarial models to develop capitation rates for the covered population of children as well as subcapitation rates for children with serious emotional disturbances. In North Carolina, Dr. Lenore Behar, director of child mental health services for that state's Division of Mental Health, not only successfully obtained a model Robert Wood Johnson site in the Asheville/Buncombe County area, but was also responsible for the implementation of the Ft. Bragg Demonstration Project, the largest totally developed system of care and continuum of services project in the U.S.. The results and lessons of the Ft. Bragg project are still being analyzed; for example, although inpatient and residential utilization were significantly reduced, there are questions as to whether cost savings were truly achieved (Bickman, Helflinger, Pion, & Behar, 1993). In the meantime, building on the Ft. Bragg experience, the Carolinas Alternatives Program has been launched in North Carolina as the largest public managed child mental health services program in the nation, involving numerous community sites and implementing community-based systems principles.

### PRINCIPLES OF COMMUNITY-BASED SYSTEMS OF CARE

The CASSP program set forth the initial principles inherent in community-based systems of care as developed by Stroul and Friedman (1986). The key aspects of these systems include: access to a comprehensive array of services, treatment individualized to the child's needs, treatment in the least restrictive environment possible (with full utilization of the resources of the family and the community), full participation of families as partners in services planning and delivery, interagency coordination, the use of case management for services coordination, early identification and intervention, smooth transition of youth into the adult service system, effective advocacy efforts, and non-discriminating, culturally sensitive services.

This latter principle was further developed by the CASSP Minority Initiative into the principles of culturally competent systems of care for children with serious emotional disturbances (Cross, Bazron, Dennis, & Isaacs, 1989), which proposed that systems of care develop practitioner guidelines for necessary attitudes, skill, and knowledge base to serve mi-



nority and culturally diverse children and families in their communities, as well as policies and procedures which remove barriers for access to services by these populations. The concept of culturally competent systems of care was a natural outgrowth from that of community-based systems of care, since the latter endorses many of the traditional cultural values of ethnic minority populations in the United States. These are particularly consonant with the cultural values of ethnic minority populations, which emphasize strong extended family involvement in the life and upbringing of children and the use of natural community resources first in dealing with the emotional and physical problems of family members. These factors have been shown to be protective from some of the morbidities associated with emotional disturbance, such as substance abuse and suicidality (Pumariega, Swanson, Holzer, Linskey, & Quintero-Salinas, 1992).

In addition to the above stated principles, there are other principles which we believe need to be adopted for the development of effective community-based systems of care:

1. *Flexible transition through levels of care.*  
Children are kept at any level of care only as long as his/her clinical condition warrants, being rapidly moved along the continuum of care as rapidly as possible.
2. *Cost-effectiveness*  
Maximum use of resources, particularly community resources and less costly and restrictive options for delivering the same level of care.
3. *High quality and accountability*  
The emphasis in these systems must be on the delivery of the highest quality of care, with a high degree of accountability through quality assurance and quality improvement mechanisms as well as the measurement of treatment outcomes and consumer satisfaction.
4. *Interdisciplinary approach*  
The involvement of multiple disciplines in their most effective roles in providing services to the child and family, with strong collaboration and integration of the skill so the different disciplines.
5. *Multimodal/integrative treatment*  
The integration of multiple treatment modalities to address the child and family's multiple problems, with flexible combination of services through wrap-around approaches to enhance services at any given level of care.

6. *Scientificallly-based but humanistic*

These systems should utilize objective decision support information, such as from standardized instruments, as well as clinical data, but need to be responsive to the humanistic needs of children and families being served.

7. *No eject/no reject*

Such systems make a commitment to serve the child and family regardless of level of severity of the child's symptoms or disturbance, level of care needed, or other complicating circumstances.

8. *Public-private integration*

The systems often involve public and private providers in close collaboration, each delivering services they are most effective with.

Another important principle inherent in this approach is that of the targeting of services to what are termed "seriously emotionally disturbed children." The formal definition of serious emotional disturbance is listed in Table 1. This definition, though it includes the presence of an Axis I diagnosis under the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM IV, American Psychiatric Association, 1994) as a criterion, places equal emphasis on the child's inability to function in at least one of his/her life domains (school, home, socially with peers). This is reflective of the difficulty that many children and their families have had in accessing necessary services when their diagnosis was not "severe enough," or when it reflected a disruptive behavior disorder. This bias still exists amongst many child mental health professionals, particularly psychiatrists, and ignores some key clinical and research observations. First, most clinicians have had children in treatment who have been diagnosed with serious disorders, such as schizophrenia, but have been totally able to function in their homes with treatment and some community supports, while other children with diagnoses reflecting disruptive behavior disorders have necessitated the most restrictive levels of care available. Some studies indicate lack of clarity and validity in clinical child diagnosis, especially in relation to the prognosis of the child, with many children with disruptive behavioral disorders having co-morbid serious mental illness when evaluated systematically (Caron & Rutter, 1991). These problems are more pronounced in the diagnostic assessment of ethnic minority youth with serious emotional disturbance, with serious underestimation of co-morbid affective and substance abuse disorders and overestimation of psychotic and organic disorders by clinicians (Kilgus, Pumariega, & Cuffe, 1995). Other studies indicate that the level of care received by children is only partially



**Table 1.** Federal Definition for Serious Emotional Disturbance

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Children with a serious emotional disturbance are persons: from birth up to age 18; who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified with DSM-III-R, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

These disorders include any mental disorder (including those of biological etiology) listed in DSM-III-R or their ICD-9-CM equivalent (and subsequent revisions), with the exception of -R "V" codes, substance use, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.

Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

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<sup>1</sup>Center for Mental Health Services (1993). *Federal Register*, 58, 29422-29425.

accounted by their clinical diagnosis, with much of it accounted by their level of function and psychosocial stressors (Silver et al., 1992).

### **THE COMMUNITY-BASED SYSTEMS APPROACH TO MANAGED CARE**

The movement to managed behavioral health services necessitated the application of community-based systems of care principles in these services. These principles actually embody a true managed care philosophy, i.e. care management becomes the primary modality for services utilization management rather than arbitrary, a priori benefits management. This approach, combined with the principles of least restrictive levels of care, result in children actually receiving higher quality services with less disruptiveness to their lives and development and at a lower cost than when more restrictive, higher levels of care are utilized.

In order to promote the implementation of these principles in publicly funded managed behavioral services, particularly Medicaid managed care where children would be primarily covered, the Task Force on Community-Based Systems of Care of the American Academy of Child and Adolescent Psychiatry developed a publication titled *Best Principles for Managed Medicaid RFP's* (Pumariega et al., 1996a). In this publication, the



authors present how states developing managed behavioral services for children covered by Medicaid can either integrate community-based systems of care principles into their contracts with managed care providers, or into their policies and procedures for public managed services. The document covers a number of key areas generally included in the development of managed behavioral services. Key aspects of the recommended guidelines are summarized below under their respective topic heading:

### **Governance**

The managed care vendor should have an advisory board that includes public representatives, private purchasers, consumers, and state personnel. It should provide its articles of governance for review during the selection process. It should recognize the autonomy and reasonable authority of the family in deciding on appropriate treatment and services. Appeals procedures and mechanisms should be outlined and readily provide them to families upon enrollment, with all appeals procedures leading to state-level appeals at the level of the purchasing authority, if unresolved at lower levels. A specialized benefit track is available for high service utilizers, with well-defined descriptions of when these benefits come into effect and a risk-adjusted subcapitation rate for this population. This latter feature serves to reduce the financial risk for the managed vendor as well as to safeguard the adequate funding of longer-term and more intensive treatment and rehabilitative services for the population of children in greatest need.

### **Benefit Design**

Benefit limits are unnecessary. Resource allocation should be based on clinical protocols and criteria that ensure that patients and families receive services according to their unique needs. The vendor agrees that members cannot be ejected or rejected from the benefit plan due to their clinical condition or level of service need without cause. The array of services the vendor provides also addresses the broader mental health needs of the community and the covered population. The vendor is also able to administer a flexible benefit design through a credentialed provider network capable of delivering specialized services unique to children with serious emotional disturbances. The use of "pooled" or "blended" funding is recommended, combining multiple sources (Medicaid/federal, state, local, non-profit) to enable managed care providers to provide combined, "wrap-around" services. This also enhances available funding through mak-

ing available mental health dollars spent by other agencies, often on the same population of children and youth through duplicated services.

### **Access to Care**

The state Medicaid program will establish access protocols for developmental, socioeconomic, geographic, and cultural needs of children, families, and communities. The vendor should establish a 24-hour 800 number, staffed by live agents to provide the following services: crisis hotline, crisis referrals, routine service requests, and benefit certification. Vendor should have available licensed clinicians for crisis calls and referrals. Children and families have access to early intervention, prevention, family peer support, and advocacy services. Emergency services are available at service sites or by direct deployment, and emergency professionals have appropriate training and credentials for serving children and families in crisis. Services should be logistically convenient to the child and family, taking into consideration the geography, public transportation, and availability of social services.

### **Assessment and Triage**

A triage system must exist with established guidelines for directing children and families to services and providers appropriate to their special needs. A full interdisciplinary team, including a child and adolescent psychiatrist, must be involved in the development of triage procedures and protocols. Comprehensive mental health assessments, the content of which are outlined, are made only by licensed providers who are credentialed and trained to conduct assessments of the special needs of children. Standardized measures should be utilized whenever appropriate. These should be reliable, valid, clinically useful, culturally competent to the population being served, and useful for programmatic evaluation.

### **Care Plan Development**

The vendor should identify children and families who require time-limited, less intensive services, with the initial care plan is developed by a licensed mental health professional in consultation with a child and adolescent psychiatrist or psychiatrist with significant experience working with children and youth. The initial care plan on children requiring more extensive treatment is developed by the inter-disciplinary team, including all



relevant child mental health and child service professionals. The parent(s), other relevant family members, and the child, if appropriate, should be members of this team. The care plan should clearly identify the coordinator of services. The plan identifies problem areas and deficits of function that prevent the child and family from functioning independently and appropriately, and it identifies interventions to address these problems. The care plan should detail and support the child's and family's strengths and skills. The patient/family should be equal participants with the clinical team in the implementation of the plan of care. Care plans should be individualized to the needs of the child and family, including attention to cultural issues, and they are recorded in a unified form that follows the child throughout service delivery. The plan of care should include continuous communication and integration of all applicable services and agencies that have responsibilities for providing services to the child and family (such as primary care, juvenile justice, schools, and social services).

### **Treatment Services**

Treatment and other services should be specific to the unique needs of children and their families, and particularly to the needs of children with serious emotional disturbance. Child and adolescent psychiatrists, psychologists, social workers, psychiatric nurses, and other members of the team should participate in the development of service protocols to ensure that the special developmental, physical, mental, and emotional needs of the child are addressed. The system should have available expertise in as many diverse therapeutic modalities with children and families as possible, particularly in those that have demonstrated effectiveness with seriously emotionally disturbed children. The vendor should address how it will deal with treatment mandates from Juvenile Justice, Child Welfare, Special Education, courts, and other agencies, including how these service needs will be integrated into the care plan. Access to the high utilizer track for children with SED should be well-defined and based at least on functional impairment as influenced by support systems and risk factors, with criteria independent of assigned Axis I or II diagnosis. Services in this track should include long-term case management and continuous clinical follow-up services, as well as intermittent acute services at times of crisis or developmental change.

### **Case Management**

Case management services are provided, including assessment of problem areas, measurement of functioning level, determination of needs,

linkage with necessary resources, care coordination, advocacy, and monitoring of services provided and their outcomes. The frequency and intensity of case management services will be proportional to the clinical and psychosocial needs of the child and family. Continuous case management specific to the unique needs of children with serious emotional disturbances and their families should be provided, in most cases throughout the child's enrollment in the vendor's plan. The patient/family are participants in the case management process, with shared responsibility with case managers for utilizing and coordinating services. Case management protocols should facilitate the coordination of multiagency, multi-system interventions, integrating services from the various providers and agencies responsible for serving the child, and ensure coordination of services with primary care physicians and health providers.

### **Quality Assurance/Improvement**

The managed care vendor must provide a detailed plan for quality improvement and utilization review. There should be periodic measurement, reporting, and analysis of well-defined indicators of service quality, including surveys of patient/family satisfaction with various aspects of the program. The RFP should specify a minimum number of quality improvement studies and indicators, with the vendor then adding further recommendations in their proposal. Areas of negative outcomes and delivery of inappropriate treatment are particularly important areas to focus on. There is periodic assessment of clinical and functional outcome, with vendors describing in detail methods and tools they will use. Vendors must demonstrate the ability to practice continuous quality improvement in their delivery systems and their components. The RFP should specify a minimum set of credentialing standards for providers under the plan, including credentials for child mental health providers. Training in cultural competence, applicable to the culturally diverse populations being served, should be part of minimum credentials. The vendor provides criteria for provider enrollment into the plan or network as well as criteria for provider termination or delisting. These criteria must be related to quality assurance/ improvement and credentials monitoring.

### **Provider Supports**

The division of responsibilities among clinicians and other providers of services, including services provided as part of the general health versus mental health benefit, should be well defined and agreed to by all parties.



The attending clinician and/or treatment team leader is notified of requests for emergency and/or protective services in a timely fashion. The division of responsibilities among state health and human services agencies providing services to the Medicaid-eligible population should be well defined through inter-agency memoranda of agreements or legislative provisos. Such agreements need to delineate access procedures for mandated services outside the scope of the plan. The vendor must be notified if a covered child is being considered for special educational services well before the IEP meeting to coordinate services with schools. The managed care vendor supports the providers' efforts to maintain continuity of care when there is a change in the contract or patient eligibility.

### **Information Management**

The state Medicaid program should establish minimum reporting requirements, including administrative and clinical measures. The vendor should demonstrate the capacity to determine clinical outcomes, costs, and quality indicators from its management information system (MIS). The MIS should be based on the system's clinical database, which derives its information from defined fields in the clinical record format. A single, unified clinical record should include an individualized treatment plan that actively reflects continuous coordination across all agencies and providers delivering services. This record should include the use of quantitative and qualitative assessment measures, standardized measures of clinical and functional outcome, and measures of the effectiveness of implementation of therapeutic interventions, as well as compliance with them by clients and families. The clinical database should contain de-identified information to assist in cost analysis, outcome evaluation, and quality assessment and improvement activities. The managed care vendor should utilize data from federal and state health and human service agencies, available relevant epidemiological studies, and other available data sources (including studies it may choose to conduct and its own database) to develop prevalence estimates on behavioral illness and service need in the plan membership in order to develop an appropriate risk adjustment. The governing authority, or consultants it may designate, should have access to aggregate data sets of the vendor's database in order to monitor contract performance and to study services utilization trends for the purpose of public policy development.

Given the complexity of these new systems of care, the skills which clinicians must bring and the roles which they play in them go far beyond the circumscribed professional roles which are delimited to their disciplines. These roles include: front-line clinician, clinical consultant to other profes-

sionals, clinical team leader, administrative leader in delivery organization/system, quality assurance/improvement consultant, consultant to interagency teams, and outcome evaluator/researcher in systems of care. On the other hand, given the emphasis on tertiary care models of care in the training of many child and adolescent mental health professionals, they have often failed to develop the necessary skills for functioning as effective members and leaders of these new systems. The AACAP Task Force on Community-Based Systems of Care has also developed a document titled *Guidelines for Training in Community-Based Systems of Care for Seriously Emotionally Disturbed Children* (Pumariega et. al., 1996b). This document, although specifically addressing the training of child and adolescent psychiatrists, provides guidance to training programs in many disciplines in the development of didactic and clinical curricula that will prepare graduates to serve in the above listed roles within these emerging systems. The curriculum suggests an array of skills (consultation, treatment planning, administration, leadership, cultural competence, system intervention), areas of knowledge base (such as dual disorders, quality improvement/ total quality management, funding mechanism, use of information systems, epidemiology and public health approaches), and attitudes ( flexibility, consistency, acceptance and welcoming of diversity, acceptance and welcoming of parents/family members as resources and partners, awareness of strengths and limitations of one's own knowledge and skills and those of other professionals).

## CONCLUSIONS

The community-based systems of care model goes beyond simple managed care and provide the basis of a truly comprehensive approach to child mental health services delivery and the necessary resource management and accountability. Its effectiveness in service delivery and in resource management is being demonstrated in many model demonstration programs throughout the United States. It brings child and adolescent psychiatry back to its roots as a community-based specialty and has the potential to maximize the role of child and adolescent psychiatrists in this age of scarcity of resources.

The *Best Principles for Managed Medicaid RFP's* have been reviewed by the Medicaid agencies of over 30 states, with some states already moving to implement many of these guidelines in their managed Medicaid contracts or in pilot demonstration programs. The American Academy of Child and Adolescent Psychiatry has also mobilized an advocacy effort through its



regional branches to promote the adoption of these guidelines in the design of either privately contracted or publically operated managed systems.

The challenge for governmental entities, managed care contractors, professional organizations, and academic programs is to move to integrate these tenets in their services, policy, academic, and professional development activities. We must also expand collaboration amongst all child mental health disciplines and with consumers/ families to advocate for their implementation in the service system to ensure quality services for children and their families.

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