Systems of Care

ISSUE BRIEF

A FRAMEWORK FOR SYSTEM REFORM IN CHILDREN'S MENTAL HEALTH

Recently, there have been renewed calls for reform in the delivery of children's mental health services. In September, 2000, the Surgeon General of the United States sponsored a conference exploring needed changes in children's mental health and issued a "national action agenda" (U.S. Public Health Service, 2000). A symposium on the subject was held at the Carter Center in November, 2001, also resulting in action steps for reform.

Increasingly over the past 15 years, the concept and philosophy of a "system of care" has provided a guide and organizing framework for system reform in children's mental health. As the field has begun to consider the action steps needed to improve children's mental health services in today's environment, much consideration also is being given to examining how the system of care concept has evolved and how it remains useful as a framework for reform. Though some have questioned the utility of the system of care approach and the place of systems of care in future children's mental health reform, others have contended that misunderstandings of the system of care concept itself underlie some of these questions and that the concept and philosophy continue to provide a valuable framework for reform.

The purpose of this issue brief is to re-examine system reform in children's mental health, clarify what the system of care concept is, and explore the continued relevance of the system of care concept and philosophy as a framework for reform. Four questions are addressed:

- *What kind of system reform is needed for children's mental health care?*
- *What is the actual meaning of the system of care concept?*
- *Why should we continue to use the system of care concept and philosophy as a framework for system reform in children's mental health?*
- *How can we achieve our system reform goals in children's mental health?*

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1 What kind of system reform is needed for children's mental health care?

Calls for reform in children's mental health date back to the 1960s. In nearly all the reports and documents advocating system change, the major themes were the same, documenting that not enough children in need were accessing services and that the services that were provided were not effective (Joint Commission on the Mental Health of Children, 1969; President's Commission on Mental Health, 1978; U.S. Congress Office of Technology Assessment, 1986). Specifically, the themes were that:

- Most children in need simply were not getting mental health services.
- Those served were often in excessively restrictive settings.
- Services were limited to outpatient, inpatient, and residential treatment. Few, if any intermediate, community-based options were available.
- And the various child-serving systems sharing responsibility for children with mental health problems rarely worked together.

Later, two additional problems received increasing attention as well:

- Families typically were blamed and were not involved as partners in their child's care (Friesen & Huff, 1996).
- And agencies and systems rarely considered or addressed cultural differences in the populations they served (Isaacs-Shockley, Cross, Bazron, Dennis, & Benjamin, 1996; U.S. Department of Health and Human Services, 2001).

The proposed solution to these systemic problems was comprehensive, community-based systems of services and supports, which eventually became known as "systems of care." Such systems of care emphasize a wide array of services, individualized care, services provided within the least restrictive environment, full participation of families, coordination among child-serving agencies and programs, and cultural competence.

Since the mid 1980s, there has been a great deal of progress across the nation in developing systems of care (Stroul, 1996). The federal Child and Adolescent Service System Program (CASSP) was initiated by the National Institute on Mental Health in 1984 (later administered by the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration) to help states and communities begin to plan for and implement systems of care. Most notably, there is now a $92 million federal program to support the development of systems of care in communities across the nation—the Comprehensive Community Mental Health Services for Children and Their Families Program. Sixty-seven communities have been funded thus far with more to come (Center for Mental Health Services, 2001). Further, there have been significant state and local investments to create systems of care. Although much progress has been achieved, there are still many communities throughout the nation without well developed systems of care, and there is clearly much work yet to be done. Today, the development and improvement of systems of care remains a widely accepted goal in children's mental health. As Mrs. Rosalynn Carter wrote in her foreword to the book *Children's Mental Health: Creating Systems of Care in a Changing Society* (Carter, 1996), "Is it too inconceivable to dream that by 2009 [which will be the 100th anniversary of the first White House conference on the needs of children] there would be systems of care for children with mental health needs in all of our nation's communities?" (p. xiv).

Current discussions of needed reforms in children's mental health focus on asking how children and adolescents with emotional disorders (including those at risk) and their families can be better served and supported. Improvements in

many areas of service systems and treatment interventions are sought, including improved access to mental health services, engagement of children and families in care, cost-effectiveness of services, efficacy of treatment interventions, integration of care across systems, involvement of families and youth, and attention to cultural differences. Calls for increased investment of resources in children's mental health services continue, reflecting the current reality of insufficient service capacity to meet the needs (Stroul, Pires, & Armstrong, 2001). In identifying needed improvements in services and service systems, many have arrived at similar conclusions to those reached by earlier reformers—that children with emotional disorders and their families need a range of comprehensive, individualized, coordinated services and supports; that all key partners must come together to plan for and deliver these services; that families must be full partners; and that cultural competence in service delivery is critical. These are the fundamental elements of the system of care concept and philosophy that emerged in the 1980s. This concept continues to offer a framework for system reform in children's mental health, although the field's understanding of the concept and how it is implemented have changed through ongoing system development activities, and will continue to evolve as reforms progress.

2 | What is the actual meaning of the system of care concept?

Myths About Systems of Care

Over time, there have been a lot of interpretations attached to the term "system of care." It has been called a "model," and people have tried to "replicate" it, to "operationalize" it, to measure it, to evaluate it, and to compare it to "traditional" services. In addition, a number of inaccurate interpretations of the meaning of the system of care concept have emerged. Some of the "myths and misconceptions" about systems of care include the following:

- They are primarily designed to improve service coordination and integration.
- They do not focus on clinical interventions but mostly focus on system infrastructure.
- The philosophy is primarily focused on family involvement and cultural competence.
- They are different from and/or do not involve evidence-based interventions.
- No "traditional" services are included in them.
- They primarily involve providing "wraparound" services.
- They place greater value on nonprofessional service providers and natural supports than on other clinicians, providers, and treatment modalities.

Defining the System of Care Concept

The definition first published in 1986 (Stroul & Friedman) states that a system of care is:

> *A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families (p.3).*

The system of care concept was originally crafted for children with *serious emotional disturbances* (diagnosable mental health disorders with extreme functional impairment that limits or interferes with the ability to function in the family, school, and/or community), although the applicability of the concept and philosophy to other populations has become obvious.

The core values of the system of care philosophy specify that services should be community based, child centered and family focused, and culturally competent, and the guiding principles specify that services should be (Stroul & Friedman, 1986; Stroul & Friedman, 1996):

- Comprehensive, with a broad array of services;
- Individualized to each child and family;

- Provided in the least restrictive, appropriate setting;
- Coordinated both at the system and service delivery levels;
- Involve families and youth as full partners; and
- Emphasize early identification and intervention.

The system of care concept recognizes that children and families have needs in many domains and promotes a holistic approach in which **all** life domains and needs are considered in serving children and their families, rather than addressing mental health treatment needs in isolation. Accordingly, the system of care framework is organized around eight overlapping dimensions, each representing an area of need for the child and family (Stroul & Friedman, 1986; Stroul & Friedman, 1996).

The mental health dimension is emphasized due to its obvious importance for children with emotional disorders, and includes a range of both nonresidential and residential services and supports. Experience has demonstrated the need to expand the definition of mental health services and has shown that additional services,

System of Care Values and Principles

Core Values

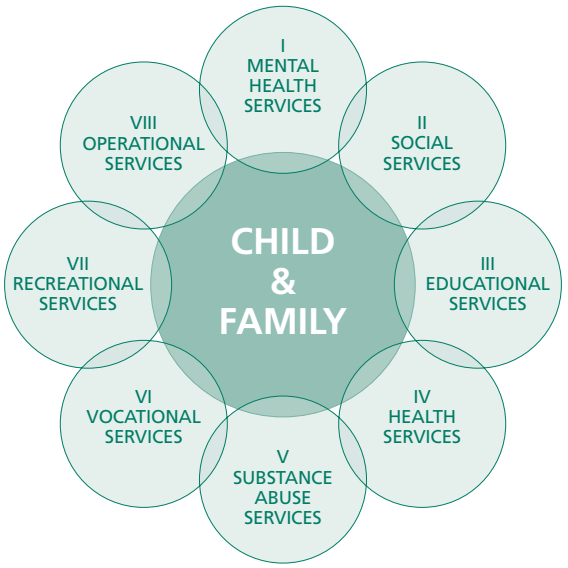
1. The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the 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 their physical, emotional, social, and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
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 adolescents with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

From Stroul, B. & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (rev. ed., p. 17). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

System of Care Framework



From Stroul, B. & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (rev. ed., p. 30). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Mental Health Dimension

Nonresidential Services	**Residential Services**
Prevention	Therapeutic Foster Care
Early Intervention	Therapeutic Group Care
Assessment	Therapeutic Camp Services
Outpatient Treatment	Independent Living Services
Home-Based Services	Residential Treatment
Day Treatment	Crisis Residential Services
Crisis Services	Inpatient Hospitalization

Other Essential Services:
Case Management
Respite Services
School-Based Mental Health Services
Behavioral Aide Services
Mental Health Consultation

such as respite care, school-based mental health services, mental health consultation, behavioral aide services, and case management, also are essential.

Several points were emphasized about the mental health dimension in 1986; these remain equally relevant today. First, all of the components are interrelated, and so the effectiveness of any one component is related to the availability and effectiveness of all other components. Because of this interdependence, when investing in building service capacity, it is important to pay attention to the entire system, not just to one or two of the services.

Second, an appropriate balance between the components of a service system is important, particularly between the more restrictive and the less restrictive services. And third, the field must stop confusing the concepts of treatment intensity, treatment restrictiveness, and treatment setting—intensive treatment interventions (even the *same* treatment interventions) can be offered in a variety of settings and service programs.

Given this review of the definition of the system of care concept, the myths can easily be re-examined. Service coordination and interagency collaboration are **elements** of the system of care philosophy, as are family involvement and cultural competence. The development of the infrastructure for a system of care is important. But none of these elements is the **sole** focus of system of care development. First and foremost, systems of care are *a range of treatment services and supports guided by a philosophy and supported by an infrastructure.*

System of Care Concept

Systems of Care and Evidence-Based Interventions

Particular attention must be given to the mistaken view that systems of care involve neither clinical interventions in general nor evidence-based interventions in particular. *At the core of systems of care are clinical services.* Further, a primary goal of systems of care is to provide state-of-the-art, effective clinical services and supports, indicating that evidence-based clinical interventions are integral.

A great deal of attention has been given to the need to ensure that interventions in both the physical and mental health arenas have a sound, scientific evidence base. No one would argue with the premise that treatments should be scientifically proven. However, it is important to note that, in reality, most interventions have not been tested on the population typically served by systems of care. In clinical research, the emphasis has been on the application of a well-defined treatment delivered to a set of children with well-demarcated problems (Friedman, 2001; Shirk, 2001). In contrast, systems of care serve a *highly diverse* population of children with multiple needs, problems, and co-occurring conditions and who receive *multiple* services and supports. Little is actually known about whether these treatments are effective within operating community service systems (Friedman & Hernandez, 2001).

The pressure to focus our research and practice on evidence-based interventions in children's mental health has led to several important observations:

- Gonzales, Ringeisen, and Chambers (2002) emphasized the importance of examining the *context* in which evidence-based interventions have been applied.
- Hernandez and Hodges (2002) pointed to the danger that the field may turn to evidence-based practice as an alternative rather than a complement to systems of care, and that services, even if proven effective, still need to reside and flourish in systems that ensure access and quality and adherence to system of care values.
- Jensen, at the recent Carter Center symposium, noted that not all services have a strong evidence base at this time. He stated that where there is not an evidence base, *common sense and experience* take over (Jensen, 2001). He further emphasized the importance of building efficacious treatment interventions within "effective, compassionate and competent systems of care" (Jensen, 2002).

Thus, while maintaining the goal of establishing a scientific evidence base for the interventions used in children's mental health, it is essential not to lose sight of:

- The importance of considering and studying clinical interventions in the context of the service systems through which they are provided, and with attention to the diversity and complexity of the populations served.
- The importance of using common sense and experience to make decisions about services where an evidence base has yet to be developed.
- The importance of identifying unique and creative practices within systems of care that are candidates for development of an evidence base.
- The importance of not allowing innovation to be stifled by the desire to use only proven interventions.
- The importance of incorporating evidence-based practice into systems of care where data do exist, and supporting the use of effective clinical practices through training.
- The importance of broadening the concept of evidence-based interventions to include evidence-based *processes* that may cut across a number of clinical interventions, such as relationship building or the wraparound approach to service delivery.

- The importance of defining what constitutes "evidence," and the research methods considered acceptable for providing evidence, more broadly to ensure their relevance to operating community-based service systems.
- The importance of not perpetuating a false dichotomy between the concepts of evidence-based interventions and systems of care—they go hand in glove.

Returning to the myths once again, it is clear that systems of care *do* involve clinical interventions, and they involve "traditional" services such as outpatient, inpatient, and residential treatment, as well as more recently developed service modalities such as home-based services, therapeutic foster care, multisystemic therapy (MST), intensive case management, and others, many of which do have an emerging evidence base from research in community settings (Burns, Hoagwood, & Mrazek, 1999; Burns & Hoagwood, 2002). Wraparound is an *approach* to planning and providing highly individualized services and supports of all types that is used extensively within systems of care. Using the wraparound approach leads to the development of a comprehensive, holistic, individualized service plan for a child and family that brings to bear all of the needed treatment services and supports. The wraparound approach also is an *element* of the system of care concept and philosophy. Further, systems of care involve highly trained clinicians of all disciplines, as well as paraprofessionals, families as providers, and other creative staffing strategies to meet different needs. Systems of care involve **all** of these things.

Systems of Care as Complex, Multilevel Processes

It is essential to recognize that developing a system of care is a *multifaceted, multilevel* process. The process involves:

- Making changes in state policies, financing mechanisms, training, and other structures and processes to support systems of care.
- Making changes at the local system level to plan, implement, manage, and evaluate the system.
- Making changes at the service delivery level to provide a broad array of effective, state-of-the-art treatment services and supports to children and families in an individualized and coordinated manner.

Developing a system of care is a *difficult and complex process* with many challenges at each of these levels.

In an effort to clarify the "real meaning" of the system of care concept, Friedman and Hernandez (2001) recently wrote that developing a system of care is neither a specific nor a simple intervention, and that it could be seen as a general statement of "policy" indicating a desire to establish a complex system targeted at a specific population of children and families based on a widely agreed upon set of principles and values. Hernandez and Hodges (2002) wrote that systems of care may be better thought of as a cluster of organizational change strategies that are based on a set of values and principles that are intended to shape policies, regulations, funding mechanisms, services and supports. These interpretations also emphasize the complexity of the system of care concept and the fact that the "intervention" occurs on multiple levels.

Further complication in defining the system of care concept is created by several of the basic characteristics of systems of care that have become more apparent over time. First, the system of care concept is a *framework and a guide,* not a prescription. The concept of a system of care was never intended to be a discrete "model" to be "replicated;" rather, it was intended as an organizing framework and value base. Flexibility to implement the system of care concept and philosophy in a way that fits the particular state and community is inherent in the approach. Therefore, different communities have implemented systems of care in very different

ways—no two are alike. It is the philosophy, the value base, that is the constant. Hernandez and Hodges (2002) captured this notion when they said that a system of care is *"not a clean package,"* that what is commonly called a system of care can vary considerably from community to community, both within and across states, and that they are not "single, bounded, well-defined units." Each community must engage in its own planning process to plan, implement, and evaluate its system of care, based upon its particular needs, goals, priorities, and environment.

Another complication is that systems of care change and evolve over time. The policies, organizational arrangements, service delivery approaches, and treatments change and adapt to changing needs, opportunities, and environmental circumstances in states and communities, both positive and negative. For example, research through the Health Care Reform Tracking Project has shown that many systems of care have had to make substantial changes at the system and service delivery levels due to managed care reforms (Pires, Stroul, & Armstong, 2000; Stroul, Pires, & Armstrong, 2001).

Yet another complication is created by the fact that, since a system of care is "not a clean package," it is very difficult to definitively or precisely say that one community has one and another does not. It is more appropriate to define the *level* of development of a system of care—which is what the system-level assessment of the national evaluation of the children's services program conducted by ORC Macro has attempted to do, and which has proven to be challenging (Center for Mental Health Services, 2001; Brannan, Baughman, Reed, & Katz-Leavy, 2002; Vinson, Brannan, Baughman, Wilce & Gawron, 2002). Additionally, many communities in the nation have some elements of the system of care philosophy and services in place, even if they are not too far along the developmental pathway.

3 WHY SHOULD WE CONTINUE TO USE THE SYSTEM OF CARE CONCEPT AND PHILOSOPHY AS THE FRAMEWORK FOR SYSTEM REFORM IN CHILDREN'S MENTAL HEALTH?

Effectiveness of Systems of Care

In establishing why the system of care concept and philosophy should continue to provide a framework for system reform in children's mental health, the effectiveness of systems of care is an obvious consideration. Researchers have been attempting to assess the effectiveness of systems of care, and questions have been raised in the literature. The Surgeon General's Report states that research has shown positive outcomes at the system level, but that the relationship between the system level and practice level remains unclear, and that questions remain about cost (U.S. Department of Health and Human Services, 1999).

A concern, however, is that when asking whether or not systems of care are effective, some research has failed to consider the basic characteristics of systems of care that have just been reviewed:

- They are multifaceted, multilevel interventions, and so are difficult to measure. They are probably more complex and difficult to implement and take more time to implement than had ever been anticipated.
- The services in systems of care are difficult to measure because children are likely to be receiving multiple services—a *package* of flexible, individualized services and supports, not just one "treatment" that can be isolated.
- They are not a unitary approach but rather are substantially different in every community. Thus, it is difficult to group them together and measure them all in the same way.
- They are not static interventions—they are constantly changing and evolving.
- And most communities have some elements of the philosophy and services, so it is difficult, if

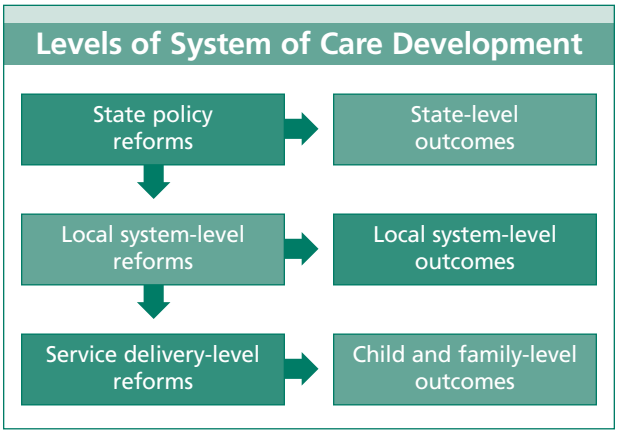
not impossible, to try to compare those "with" and those "without."

Given these complexities and variations, it is a *significant challenge* to evaluate systems of care, and there is *no one objective truth or simplistic answer* about their effectiveness—it is *not* a yes or no question.

The central issue is that when asking the question of whether systems of care are effective, one must ask *"effective for what?"* There are goals and desired outcomes at each level of the intervention, all of which are important and all of which should be considered and measured appropriately. System-level changes cannot be examined and measured by looking at clinical and functional outcomes. Those must be linked to what occurs at the service delivery or practice level. And improved clinical and functional outcomes cannot reasonably be expected if the intervention only involves system-level changes, such as building an infrastructure or coordinating. Care must be taken to ensure that the outcomes being measured are *reasonably linked* to the level and the aspect of the intervention that is being assessed.

Rosenblatt (1998) emphasized this point in stating that it is important to "match the measurement of a system of care to its *proximal organizational intentions* in order to avoid inappropriate assessment of the results of systems of care." Hernandez and Hodges (2002) raised a similar point when they stated that the system of care concept has been framed, by some researchers, as a "clinical intervention," leading to the erroneous expectation that they can be implemented and evaluated as discrete units intended to directly improve the emotional and behavioral status of children. They further suggested that child-specific clinical outcomes are best understood as resulting from the specific treatments or treatment clusters made available *through* systems of care.

The salient point is the same—that is, that systems of care involve interventions at multiple levels, that there are desired outcomes at each level, and that research assessing effectiveness should explore outcomes that are directly related to the goals and interventions at each of these levels.



Challenges to Assessing Systems of Care

At this time, there is a great deal of evidence of the effectiveness of systems of care at the system level. For example, Hoagwood and colleagues reviewed the research and pointed out that systems of care have been demonstrated to improve access to services and to reduce use of restrictive forms of care (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). There are other examples in the literature of systems of care having positive effects on system-level goals, such as avoiding residential placement costs (Rosenblatt, Attkisson, & Mills,1992). However, Hoagwood et al also noted that, although systems of care have been shown to produce improved clinical and functional outcomes for children (which is our ultimate goal), improved clinical outcomes *in relation to* comparison groups has not been demonstrated. Therefore, questions have been raised as to the "effectiveness" of systems of care.

Drawing such a conclusion raises several important points:

- As a multifaceted intervention, *no one type of measure* can be used to assess the overall or ultimate effectiveness of systems of care.

- Clinical and functional improvements must be linked to the specific treatments or package of treatments and supports delivered to a child at the practice level, just as other types of outcomes that are assessed must be related to specific goals and interventions at other levels. In fact, a major contribution of some of the early research on systems of care has been to suggest that system-level changes alone are *not sufficient* to ensure that changes will occur at the practice level. It has become apparent over time, that change just does not "trickle down" and that a great deal more attention to the practice level is needed to ensure that state-of-the-art, effective service delivery approaches and treatments are provided; that front-line staff are well trained in the system of care philosophy and in the new service technologies; and that children and families actually experience the services they receive in a way that is consistent with system of care values and principles. New methods, such as the System of Care Practice Review, have been developed as a way to better assess what occurs at the practice level, and the ORC Macro evaluation of the children's services program now includes a practice-level assessment (Manteuffel & Grossman, 2002; Hernandez, Gomez, Lipien, Greenbaum, Armstrong, & Gonzales, 2001; Center for Mental Health Services, 2001).
- It is the *relationship* between these various levels of the system of care intervention that remains unclear. A major challenge as the field moves forward is to better understand the relationship between variables at the system level and variables at the practice level—the challenge stated in the Surgeon General's report (U.S. Department of Health and Human Services, 1999).

Another important challenge for the children's mental health field is, as a community, to shift our focus from the overly simplistic, *"either-or"* question of whether or not systems of care are effective per se. More relevant in today's world are questions related to *how we can improve the systems of care* that serve children with emotional disorders and their families, and *how we can improve the services and treatment interventions* embedded within them in order to achieve better outcomes. Are systems of care serving the population that was intended? Are they providing the services and supports that were intended in the way that was intended? Did children and families experience the services and supports in the way that was intended? What are the *elements and characteristics* of systems and treatment interventions that are associated with positive outcomes at each level? These are the questions that will move the field forward.

Additionally, the current operating environment places far greater emphasis on accountability than when the system of care concept was first introduced. Ongoing research and evaluation focusing on the *process* of implementing systems of care is essential to learn more about what we are doing and how we can do it better. Though implementing and sustaining effective systems of care has been a goal, insufficient research has been focused on the process of achieving this. Communities building systems across the nation, each with unique characteristics and approaches to systems of care, offer a rich array of learning opportunities. In addition to elucidating the system building process, increased emphasis on understanding the process of system development adds a much needed focus on internal evaluation. Internal evaluation, in combination with outcome evaluation and professional development activities, comprise a commitment to "continuous quality improvement" in systems of care. The use of evidence-based practices also should be embraced by systems of care as part of this commitment to continuous quality improvement.

Value Base for System Reform

Many think that the system of care concept and philosophy *should* continue to guide system

reform in children's mental health. Why? Because its underlying premises remain sound:

- Providing a broad array of individualized services and supports.
- Serving children in the most normative and least restrictive environments possible.
- Serving children in community-based programs and not institutionalizing them unless absolutely necessary.
- Supporting and involving families in caring for their children, since, in most cases, families are the most important and life-long resource for their children.
- Agencies and programs working together and not at cross-purposes when serving children with multiple needs.
- Recognizing and addressing cultural differences.

The system of care philosophy provides a fundamental value base to guide system reform that is now widely accepted across communities, constituencies, and child-serving systems in this country. This philosophy is evident throughout the National Action Agenda that resulted from the Surgeon General's Conference on Children's Mental Health, with its emphasis on services in community settings, services that consider familial and ecological contexts, interventions to support families, cross-system collaboration and integrated care, early identification and intervention, mechanisms for input from families and youth, and culturally competent services (U.S. Public Health Service, 2000). Further, the system of care concept is now being applied in other child-serving systems and in the physical health community. The broad acceptance of the system of care philosophy across systems indicates its broad applicability and relevance to guide the delivery of health and human services for *all* children, including those with serious emotional disorders.

4 How can we achieve our system reform goals in children's mental health?

The answer in one word to this last question is—*together.* The divisions among those advocating systems of care, those questioning their efficacy, those advocating evidence-based interventions, and other groups and organizations advocating particular approaches are not likely to be helpful in advancing a reform agenda in children's mental health. In general, all stakeholders involved in improving children's mental health care have so much in common—most notably, a shared value base and philosophy. For example, Burns & Hoagwood (2002) point out that the primary characteristics of the community-based, evidence-based practices they describe is that they embrace the system of care philosophy. With that shared value base, we can *learn* from our differences and from our collective experience:

- *If* we engage in an open and honest dialogue about what is working well and what needs strengthening.
- *If* we look at both quantitative and *qualitative* data about systems and the services provided within them.
- *And if* we ask the right questions.

Although we all do not necessarily approach this from the same perspective, we all have the same ultimate goal—improving services and outcomes for children and adolescents with mental health problems and their families.

Over time, there has been extraordinary progress toward the development of community-based systems of care. Accomplishments are evident at the national, state, and local levels, and span areas including the elucidation of the system of care concept and philosophy, the development of new services, the formation of an advocacy movement, the improvement of interagency collaboration, and the stimulation of research. Although gains have been substantial, great

challenges lie ahead in the endeavor to develop systems of care (Stroul, Friedman, Hernandez, Roebuck, Lourie, & Koyanagi, 1996). Some of these represent areas in which the field has not focused sufficient attention; others result from changes in the environment in which systems of care are evolving. Contemplation of the reasons why it has been difficult to implement and sustain systems of care raises a number of questions:

- Is the system of care concept still not sufficiently known, understood, or accepted?
- Are the incentives to implement systems of care inadequate?
- Is there insufficient funding by mental health and other child-serving systems to accomplish system development and to develop needed service capacity?
- Are managed care reforms and other cost containment and financial retrenchment measures across states diverting both attention and investment away from system of care development?
- Is system development impeded by the lack of a pool of staff who are prepared with the philosophy and skills needed to work within a system of care context?
- Has insufficient attention been focused on working with front-line staff in order to work towards changing attitudes and practices at the service delivery level?
- Are system development efforts in communities not sufficiently well linked to state policies and strategies for sustaining systems of care and disseminating the system of care philosophy and approach statewide?
- Are resources for providing technical assistance and support for the development of systems of care inadequate?

These and other factors pose formidable and continuing challenges to developing and improving systems of care. Despite these implementation challenges, however, the system of care concept and philosophy continue to offer a value base and framework to guide the development and improvement of services for children and adolescents with serious emotional disorders and their families.

References

Brannan, A., Baughman, L., Reed, E., & Katz-Leavy, J. (2002). System of care assessment: Cross-site comparison of findings. *Children's Services: Social Policy, Research, and Practice,* 5, 37-56.

Burns, B. & Hoagwood, K. (2002) *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press.

Burns, B., Hoagwood, K., & Mrazek, P. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review,* 2, 199-254.

Carter, R. (1996). Foreword. In B. Stroul (Ed.), *Children's mental health. Creating systems of care in a changing society.* (pp. xiii-xiv). Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

Center for Mental Health Services. (2001). *Annual report to Congress on the evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program:* Atlanta, GA: ORC Macro. Manuscript in preparation.

Friedman, R. (2001). The practice of psychology with children, adolescents, and their families: A look to the future. In J.N. Hughes, A. M. LaGreca, & U.C. Conoley (Eds.), *Handbook of psychological services for children and adolescents* (pp 3-22). New York: Oxford Press.

Friesen, B. & Huff, B. (1996). Family perspectives on systems of care. In B. Stroul (Ed.), *Children's mental health. Creating systems of care in a changing society.* (pp. 41-68). Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

Hernandez, M., Gomez, A., Lipien, L., Greenbaum, P., Armstrong, K., & Gonzales, P. (2001). Use of the system of care practice review in the national evaluation: Evaluating the fidelity of practice to system-of-care principles. *Journal of Emotional and Behavioral Disorders,* 9, 43-52.

Hernandez, M., & Hodges, S. (2002). *Building upon the theory of change for systems of care.* Manuscript submitted for publication. University of South Florida, Louis de la Parte Florida Mental Health Institute, Tampa.

Hoagwood, K., Burns, B., Kiser, L., Ringeisen, H., & Schoenwald, S. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services,* 52, 1179-1189.

Isaacs-Shockley, M., Cross, T., Bazron, B., Dennis, K., & Benjamin, M. (1996). Framework for a culturally competent system of care. In B. Stroul (Ed.), *Children's mental health. Creating systems of care in a changing society.* (pp. 23-40). Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

Jensen, P. (2001). Presentation at: The Seventeenth Annual Rosalynn Carter Symposium on Mental Health Policy. *Youth in crisis: Uniting for action.* Atlanta, GA. November 7, 2001.

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

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.

Manteuffel, B. & Grossman, L.S. *Assessment of caregiver service experience at the practice level in system-of-care and non-system-of-care communities.* University of South Florida Research and Training Center for Children's Mental Health: 15th Annual Research Conference. A system of care for children's mental health: expanding the research base, March 4, 2002. Tampa, FL.

Pires, S., Stroul, B., & Armstrong, M. (2000). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—1999 impact analysis.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

Stroul, B., Pires, A. & Armstrong, M. (2001). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—2000 state survey.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

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

Rosenblatt, A. (1998). Assessing the child and family outcomes of systems of care for youth with serious emotional disturbance. In M. Epstein, K. Kutash, and A. Duchnowski (Eds.). *Outcomes for children and youth with behavioral and emotional disorders and their families.* (pp. 329-362). Austin, TX: Pro-Ed, Inc.

Rosenblatt, A., Attkisson, C., & Mills, N. (1992). *The California AB377 evaluation, three year summary report.* San Francisco: The University of California.

Shirk, S. (2001). The road to effective psychological services: Treatment processes and outcome research. In J.N. Hughes, A. M. LaGreca, & U.C. Conoley (Eds.), *Handbook of psychological services for children and adolescents* (pp 3-22). New York: Oxford Press.

Stroul, B. (1996). Introduction: Progress in children's mental health. In B. Stroul (Ed.), *Children's mental health. Creating systems of care in a changing society.* (pp. xxi-xxxii). Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

Stroul, B., & Friedman, R. (1986). *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., & Friedman, R. (1996). The system of care concept and philosophy. In B. Stroul (Ed.), *Children's mental health. Creating systems of care in a changing society.* (pp. 1-22). Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

Stroul, B., Friedman, R., Hernandez, M., Roebuck, L., Lourie, I., & Koyanagi, C. (1996). Systems of care in the future. In B. Stroul (Ed.), *Children's mental health. Creating systems of care in a changing society.* (pp. 591-612). Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.

U.S. Public Health Service, *Report of the Surgeon General's Conference on children's mental health: A national action agenda.* Washington, DC: 2000.

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

Vinson, N., Brannan, A.M., Baughman, L., Wilce, M., & Gawron, T. (2001). The system-of-care model: Implementation in twenty-seven communities. *Journal of Emotional and Behavioral Disorders,* 9, 30-42.

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