

American Academy of Child
and Adolescent Psychiatry

**GUIDELINES FOR TRAINING TOWARDS
COMMUNITY-BASED SYSTEMS OF CARE FOR
CHILDREN WITH SERIOUS EMOTIONAL
DISTURBANCES**

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II. PREAMBLE

Community-based systems of care for children and adolescents with serious emotional disorders (SED) and their families have developed rapidly over the past few years. Initially, the conceptual impetus for such programs came from advocates such as Knitzer (1982), who identified this highly underserved segment of the population of children in the United States. Later, the Child and Adolescent Services Systems Program (CASSP, formerly out of NIMH and now out of CMHS) and private foundations, such as the Robert Wood Johnson and Casey Foundations, began designing conceptual frameworks and implementing model demonstration programs. These programs addressed the needs of children with SED and their families in the least restrictive, most comprehensive manner within the budgetary constraints faced by public mental health agencies (Stroul & Friedman, 1986; England & Coles, 1992). Most recently, the emergence of managed care has increased the impetus for developing such systems as alternatives to traditional approaches, which relied chiefly on inpatient hospitalization and categorical outpatient aftercare.

Systems of care are increasingly the main configuration for child mental health services in many communities. However, with some exceptions, child and adolescent psychiatrists have not been integrally involved in the conceptual development and implementation of these community-based systems of care. Most of this work has been performed by non-medical, mental health disciplines. As a result, such systems have often missed the broad biopsychosocial, developmental perspective and multimodal clinical skills which child and adolescent psychiatrists can offer. On the other hand, child and adolescent psychiatrists have traditionally used centralized approaches to child mental health care delivery, exemplified by the large, free-standing psychiatric hospitals and clinics of the 1970s and '80s. As a result, many of them now find themselves interacting with community-based systems of care with little understanding about their philosophy, organization, and operational characteristics.

The AACAP Task Force on Community-Based Systems of Care for SED Children was appointed by President William Ayres, M.D., to bring child and adolescent psychiatry "up-to-speed" and, as appropriate, to enhance the specialty's role in these rapidly evolving systems of care. Part of the charge to the Task Force is to develop guidelines for residency programs to implement educational experiences that would provide trainees with the competencies needed to function effectively within such settings.

It is in the context of providing community-based mental health services for children and their families, as well as serving as tertiary expert consultants, that child and adolescent psychiatrists can maximize their potential. This involves defining their special domains of expertise, as well as sharing major responsibility for the clinical and staffing needs of their communities and providing training and research opportunities.

In recommending curricular guidelines for the training of child and adolescent psychiatrists in autonomous departments or divisions of child psychiatry, we do not seek to supersede the requirements for child and adolescent psychiatry residency training programs established by the Psychiatry Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (ACGME). However, within these requirements, we seek a balance between different learning experiences that would enable trainees to become tertiary specialists in complex and new ways of understanding psychiatric illnesses in children and adolescents. This is especially true as we are elaborating and re-defining our identity as a specialty, coming from such origins as community child guidance clinics (a uniquely American model) and pediatrics.

Because of its emphasis on child and adolescent development and psychopathology, it is highly desirable that child and adolescent psychiatry be collaborative with adult psychiatry yet independent and primarily responsible for its own training, research, and development of relevant clinical services for the communities and regions it serves.

A training center is well advised to create a learning environment that incorporates multidisciplinary collaborations and reflects how it fits into and provides relevant services for its community. Similarly, this learning environment

demonstrates that hospitals and residential treatment centers do not dominate the service system, but are integral extensions of a community and family-based, child-centered, clinical service system.

Child and adolescent psychiatry training programs should also understand and accommodate the history and cultures of their communities. This approach ensures that the treatment addresses all of the vital aspects of child life, including home, school, primary health setting, child welfare and protection, courts and juvenile corrections, and recreational and preventive areas. Training that develops the knowledge base, skills, competencies and attitudes for child psychiatrists to function effectively in community-based systems of care will ensure that graduates can better assume the full responsibilities for our field in this new and challenging mental health care environment.

III. CHARACTERISTICS OF COMMUNITY-BASED SYSTEMS OF CARE

Below are the basic principles underlying the development and function of community-based systems of care for children with serious emotional disturbances, the continuum of services involved, and the many potential roles for child and adolescent psychiatrists.

A. Principles of Community-Based Systems of Care:

1. Child-Centered, family-oriented: These are to be driven by the individual needs of the child being served. Care providers collaborate respectfully with families as partners in assessment/diagnosis, treatment planning and service delivery, helping them to understand their role in the child's recovery, adaptation and functioning. They also involve the family and the community in the governance of the service system and have a true consumer orientation.
2. Least restrictive level of care: Children are served in the least restrictive setting that can meet their needs. Whenever clinically possible, services are modified to decrease restrictiveness.
3. Community-based: High value is placed in having the child served as close to his/her home and continuity as possible to maximally involve the family and community in treatment and other services.
4. Culturally competent: Principles of cultural competence are adhered to by clinicians and service organizations in order to address cultural biases and barriers.
5. Flexible transition through levels of care: The child is kept at any given level of care only as long as his/her clinical condition warrants and is efficiently transitioned to other levels of care when appropriate. Efforts should be made to support the continuity of the clinical team across levels of care.
6. Cost-effective: Utilization of community resources and less costly and/or restrictive options are encouraged, with the greatest proportion of funds available spent on the largest number of children possible rather than a large proportion of funds going to serve few children.
7. High quality and accountability: The emphasis in these systems is in the delivery of the highest quality of care. There is a high degree of accountability through quality assurance and quality improvement mechanisms, as well as the measurement of clinical outcomes.
8. Interdisciplinary: Multiple disciplines are involved and assigned their most effective roles in providing services to the child and family.
9. Multiagency: Since these systems serve children who are under the purview of multiple child service agencies, they require close inter-agency coordination and collaboration, with different agencies providing the services for which they are most skilled.

10. Multimodal/integrative: Multiple treatment modalities are integrated to address the child and family's various needs. Flexible combinations of resources through a wrap-around approach enhance service at every level of care.
11. Scientifically-based but humanistic: These systems are driven by objective, clinical research and program evaluation data, while also being responsive to the unique needs and perspectives of the child and family.
12. Public-private integration: The systems often involve public and private providers in close collaboration, each delivering services for which they are most effective.
13. No eject/no reject: The systems are committed to serving the child and family regardless of the level of severity of the child's symptoms or disturbance, level of care needed, or other complicating circumstances.
14. Transition to independent living and/or adult services: Systems address adolescents' skills for self-sufficiency, including vocational, educational, and independent living skills. They also assist young adults and their parents with the necessary linkages and transitions to adult services at the developmentally appropriate time.

B. Levels of Care within Community-Based Systems:

These systems include as many of the following as possible in their continuum of services (but are not limited to these). There is close integration and collaboration amongst them, including a shared philosophy, common policies and procedures, clinical documentation, and close case management throughout the continuum.

1. Routine outpatient clinic/services
2. Intensive outpatient services
3. Home-based services
4. School-based services and therapeutic classrooms
5. Partial hospital/day programs
6. Mobile emergency services
7. Outpatient crisis stabilization services
8. Crisis/observation programs
9. Respite services
10. Acute residential programs
11. Therapeutic home/foster care facilities
12. Therapeutic group homes
13. Acute inpatient services
14. Residential treatment services
15. Rehabilitative/vocational services
16. Psychoeducational services
17. Independent living programs

18. Therapeutic case management
19. Recreational therapies
20. After-school programs
21. Mental health consultation to community agencies/programs

C. Roles for Child & Adolescent Psychiatrists in Community-Based Systems of Care:

Child and adolescent psychiatrists have the potential to make significant and unique contributions due to their broad and in-depth training in child development and psychopathology. Below is a non-exhaustive list of potential roles in which child and adolescent psychiatrists can serve in these systems. However, in addition to their current training, child and adolescent psychiatrists may need expanded and/or modified training to fulfill these roles.

1. Front-line provider of clinical services
2. Advocate for the child, family and system
3. Clinical-team participant or leader
4. Clinical consultant to other professionals
5. Administrative leader in delivery organization/system (including medical directorship)
6. Quality assurance/improvement consultant
7. Consultant to interagency teams
8. Outcome evaluator/researcher in systems of care
9. Provider of in-service training
10. Case manager
11. Developer of mental health services policy and planning within communities, regions, and states

IV. GUIDELINES FOR CHILD AND ADOLESCENT PSYCHIATRY PROGRAMS

A. Knowledge/Skills needed by Child & Adolescent Psychiatrists for Community-Based Systems:

The knowledge and skills child psychiatrists need to learn in order to function effectively in community-based systems of care are outlined below. This section describes the clinical, didactic, and supervisory curriculum components necessary to provide adequate training experience. This format should enable training directors to modify their curricula by incorporating community-based system experiences, rather than having to expand an already full curriculum.

- State-of-the art clinical diagnostic skills, including the ability to utilize standardized diagnostic approaches and rating instruments, as well as evaluate changing levels of psychosocial functioning in children and adolescents to determine the presence of severe emotional disturbance and/or psychiatric illness.
- Assessment of family functioning and ability to develop a dynamic formulation of child and family structure and adaptation.
- Multimodal therapeutic skills, sufficiently flexible to accommodate and integrate different clinical and theoretical paradigms and approaches, such as biomedical, developmental, psychosocial, and rehabilitative (i.e., social skills and independent living skills training) approaches.
- Treatment planning skills, that include the integration of diagnostic, functional, developmental, and environmental information into a coherent formulation and problem/strength list, that generate a relevant and effective plan of services utilizing diverse therapeutic modalities and multi-disciplinary professionals.
- Knowledge and understanding in evaluating and treating the mental health factors and complications associated with being a victim of sexual abuse or family violence.
- Knowledge and understanding in evaluating and treatment of juvenile sexual offenders and violent juveniles.
- Knowledge and skill in evaluating and treating substance abuse disorders in children and adolescents. This should include the biopsychosocial impact of these conditions on the child and family and its interaction with serious emotional disturbance and psychiatric disorders.
- Multi-disciplinary collaborative skills, including the ability to define ones domain of knowledge and skills; respecting the competencies, limitations, and contributions of disciplines and individual professionals; recognizing situations where professional role diffusion may be appropriate; communicating with colleagues in a respectful manner, and negotiating therapeutic roles in the manner most effective for the child and family.

- Consultative skills, including the ability to listen, obtain clinical perspectives and communicate with other professionals in a sensitive manner. This should also include adhering to system organization in managing clinical disagreements, coordination of services with fellow professionals, and facilitating other professionals in effectively performing their roles and functions. These skills should be developed in working with medical colleagues as well as mental health and other human services colleagues.
- Systems evaluation and intervention skills, including assessing a system's organizational strengths and barriers and devising effective interventions for system improvement (policy change, education, communication, etc.).
- Administrative skills, including role definition, delegation, conflict resolution, organization, and communication.
- Total quality management skills, including the use of quality assurance/improvement tools and processes, with bottom-up input from front-line service staff and consumers.
- Cultural competence, including knowledge and skills related to minimizing cultural/racial biases in diagnosis, the evaluation of level of functioning, treatment, access to care, service utilization, the understanding and expression of illness, and alternative means of coping and healing.
- Knowledge of the impact of stigma of mental illness/emotional disturbance on children and families and being able to collaborate -with parents and consumer advocates.
- Understanding the role of religious beliefs and institutions in the lives of children and families, the impact of religious beliefs on mental health beliefs and services utilization, and how religious and mental health professionals can work collaboratively.
- Understanding the impact of community history, community characteristics, the composition of the population (racial, ethnic, SES, religious affiliation, etc) provider relations, and political considerations on the development of community mental health services.
- Understanding the organization's operation and the interrelations of the different agencies in systems of care for children with emotional disturbances, including mental and physical health, educational, MR/development services, social and protective services, juvenile justice, substance abuse, public health, and advocacy components.
- Understanding the funding mechanisms for different components of the service system, including knowledge about third party private payers, governmental funding mechanisms, fee-for-service systems, categorical funding, and capitation.
- Leadership skills, including understanding the critical leadership components within organizations, how leadership can be provided from both formal and informal positions of authority, communication skills, techniques in achieving clarity of goals/objectives, techniques to mobilize action, resources and understanding of pitfalls in leadership roles.

B. Attitudes needed by Child & Adolescent Psychiatrists for Community-Based Systems:

1. Well grounded identity as a child and adolescent psychiatrist.
2. Flexibility and resourcefulness.
3. Consistency and tenacity.
4. Acceptance and openness to diversity.
5. Welcoming of parents/family members as resources and partners in the treatment process, not assuming their role as causative agents.
6. Recognition of the value of consumer and community input into programs and policies.
7. Awareness of strengths and limitations of one's own knowledge and skills and those of our specialty.
8. Awareness of and respect for the knowledge, expertise and perspectives of other mental health and, child services professionals.
9. Willingness to adapt interventions to the unique needs/circumstances of the child and family.
10. Willingness to tolerate disagreement from families and allied health professionals.

C. Clinical Curriculum Components:

Traditional curricula need to be supplemented or enriched with the following experiences:

1. Outpatient rotations oriented to brief, focused treatment, psychoeducational treatment, and specialty clinics.
2. Longitudinal experiences with youth who are chronically mentally ill/emotionally disturbed, especially youth with multiple agency involvement and multiple developmental needs.
3. Interdisciplinary team experiences, as a team member (with child psychiatry and non-psychiatric leaders); as line staff in child serving agencies (RTC's, group homes, special education classes, juvenile detention clinics, etc) working with non-medical mental health and non-mental staffs, and as team leader with supervisory responsibilities.
4. Crisis emergency services experience in the community.
5. Consultation/liaison experiences with primary health care providers in community settings. These should include collaboration not only with primary care physicians (pediatricians, family practitioners, etc.), but also with non-physician practitioners such as clinical nurse practitioners and physicians assistants.
6. Community-based intensive services rotation (family preservation team, school-based day treatment, wrap-around services program, etc.).
7. Administrative experience, including both apprenticing under the leader of a clinic or agency, as well as assisting such a leader in some of his/her leadership tasks.
8. Cross-cultural rotations either in ethnically-oriented specialty settings, in service systems with concentrations of minority populations, or in religiously centered systems of care.
9. Experiences collaborating with advocacy groups (such as parent support groups) and with children with serious emotional disturbances outside clinical settings (such as a caretaker in respite camps or special home visitation).

10. Experience with children with emotional disturbances in other child service agencies, such as schools, juvenile justice/detention settings, child welfare offices, group homes, residential treatment programs, foster homes, etc.
11. Rotations in substance abuse services for adolescents and exposure to community support groups for substance-abusing teens such as AA, NA, "double trouble", relapse prevention groups, etc.
12. Experiences with families that have a child with serious emotional disturbances. Partner with a family for a year including home visitations.
13. Experience in the implementation of critical pathways of diagnostic assessment or treatment of particular disorders in various levels of care (inpatient, outpatient, and intermediate services).
14. Experience in the use of electronic technology and management information systems in patient care, quality assurance, and policy/planning.

D. Special Didactic Curriculum Components:

In addition to the typical curricular topics/components, the following components should be especially emphasized or enriched in order to prepare child and adolescent psychiatrists for these systems of care:

1. Systems theory as applied to families and organizations.
2. Social factors in normal development and emotional disturbance/mental illness.
3. Cultural competence training, including principles of cultural competence, areas of special clinical skills, and knowledge about the impact of culture on development and disorder in the main ethnic/minority groups in the U.S.
4. Epidemiology of childhood emotional disturbance/mental illness, principles of public health and prevention in child mental health, and principles of services evaluation and research.
5. Conceptual literature on systems of care for children and their families, including: basic concepts of systems of care; different components, levels of care, and agencies within the child services system; the interrelation among such components and agencies; and the roles child and adolescent psychiatrists can fulfill within such systems.
6. Conceptual literature on children with serious emotional disturbances, the independence of functional impairment from diagnostic criteria, and tools/approaches to evaluate functional impairment and strengths in children.
7. A working knowledge of core spiritual concepts of the major faith traditions in the U.S., competence in gathering a religious history, especially when relevant to mental health beliefs, and concepts of appropriate intervention or response when religious issues arise in the context of treatment.
8. Concepts of quality assurance and total quality management (TQM) and corresponding tools used when applying such principles to systems of care.
9. The use of management information systems for clinical research and quality assurance/ improvement applications.

10. Principles of health care financing and administration.
11. Principles of leadership within health care delivery organizations.

E. Supervision and Mentorship:

1. Interdisciplinary supervision facilitates the appreciation of strengths and expertise of different mental health and child service professions, as well as expands the exposure to different theoretical viewpoints in children's mental health. However, interdisciplinary supervision should not become a substitute for supervision by qualified child and adolescent psychiatrists, particularly ones with significant systems of care expertise.
2. Supervision with a systems orientation is essential not only to develop clinical skills, but also systems evaluation, consultation, and intervention skills. This orientation should be integrated into both case supervision and consultative supervision.
3. Supervision should integrate cultural and religious competence principles and utilization of natural community resources on behalf of the child and family.
4. Supervision of administrative roles should include interprofessional issues, resource allocation decisions, and coordination of interventions.
5. Modeling, supervision, and mentorship should be provided by child and adolescent psychiatrists with significant roles in systems of care.

F. Changes to Existing Curricula:

Below are recommendations on modifications to the traditional curriculum for child psychiatry residency programs in order to accommodate new components and orientation.

1. Inpatient Rotations:

- Utilize the flexibility offered in the new RRC standards for child psychiatry to offer intensive evaluation and treatment experiences in inpatient group homes or RTC's, wraparound programs, and intensive partial hospital programs, in order to increase the flexibility of practice of our graduates.
- Combine opportunity to follow children longitudinally out of inpatient services into community services.
- Emphasize multidisciplinary team work on inpatient services
- Have an administrative rotation, with particular focus on community transition and collaboration of services to patients and their families.
- Offer flexibility in treatment settings for training in intensive treatment and allowing exposure to acute, severely ill, and chronically impaired populations.
- Consider using physician extender allied professionals (especially nurse practitioners) to reduce reliance on residents for inpatient services and to train residents on working with such professionals.

2. Outpatient Rotations:

- Integrate intensive community, specialty cross-cultural, and crisis training into outpatient rotations.

- Focus psychotherapy training into a few continuous long term cases, with emphasis on children with SED.
- Allow resident to provide some case management services in collaboration with professional case management.
- Provide block experiences in brief psychotherapy (psychodynamic, behavioral family)
- Provide outpatient interdisciplinary team experiences (diagnostic teams, crisis intervention teams, etc.), with resident having opportunity to lead team as well as serve as team member.

3. Community Rotations:

- Expand integration of outpatient and community rotations so that these are increasingly seen as central to the experience of child psychiatrists.
- Encourage interagency team experiences, with modeling initially by experienced child psychiatrists.
- Use interdisciplinary team experiences in community settings, which are preferable to consulting to a single consultee.

4. Didactic Programs:

- Streamline developmental curriculum so that social, cultural, religious/spiritual and functional aspects of development are covered simultaneously with cognitive and psychological aspects.
- Streamline psychopathology so that functional assessment is integrated and initial lack of diagnostic clarity is tolerated.
- Provide access to experts in various systems issues through lectures and presentations.
- Integrate consumer and family orientation, especially in the teaching of family therapy.

5. Interdisciplinary Training.

The concurrent training of different mental health disciplines can provide an ideal setting for developing interdisciplinary skills and mutual appreciation for different areas of expertise. In fact, the strongest factor leading to the involvement of child and adolescent psychiatrists within systems of care is the familiarity that the other disciplines have with the role of child psychiatrists and their expertise. At the same time, child and adolescent psychiatry divisions serve as ideal settings for the training of psychologists, social workers, activity therapists, school counselors, educational psychologists, and many other professionals. Child psychiatry divisions and residency programs are encouraged to develop training affiliations with these Merent disciplines. They can also share some of the didactic components of child psychiatry training where applicable, as well as import the expertise of other disciplines in training their child psychiatry residents.

G. System of Care Participation by Clinical Services within C & A Divisions:

Teaching principles of community-based systems of care is most effective when the clinical programs of the division of child and adolescent psychiatry are part of such systems. This participation will be increasingly important for the financial viability of divisions given the rapid

development of managed care networks, most of which practice or will adopt such a model for child and family mental health services. Academic child psychiatry programs have a critical role to play since they can:

1. Provide much needed expertise in development, diagnosis, treatment planning, and multimodal treatment.
2. Provide appropriately trained professionals.
3. Support the development of methodology for conducting functional outcomes research.
4. Develop applications studies for innovative treatment approaches.
5. Help develop standards of clinician quality and program performance.

Another document developed by this Task Force, *Best Principles for the Development of Medicaid Managed Care RFPs*, can serve as a reference for directors of child and adolescent psychiatry programs and chairs of departments of psychiatry in their planning for services delivered by their academic programs and their integration within community-based systems of care.

V. EVALUATION OF CURRICULUM GUIDELINES:

We strongly recommend that these guidelines be modeled and tested at selected child and adolescent psychiatry residency programs in diverse sites and regions (urban vs. rural, large vs. small programs, different regions of the U.S., university hospitals vs. community-based medical schools, etc.).

A. Evaluation design:

1. Selection of residency programs to serve as alpha sites for program modeling, particularly programs with some track record in community-based systems.
2. After initial 1-2 years, selection of beta sites with little track record in community-based systems, with baseline and post-implementation follow-up measures.

B. Process evaluation:

1. Knowledge and attitude testing.
2. Supervisory skill evaluation.
3. Resident evaluation of the overall curriculum.
4. Residency director evaluation of the curriculum.

C. Outcome evaluation/Need baseline and post-measures:

1. Evaluation of the number or percent of time of graduates in community-based systems.
2. Evaluation of residents and graduates by clients/families and administrators where they work.
3. Long-term evaluation by graduates of applicability/relevance of different curriculum components and overall curriculum.

We refer residency program directors, division directors, and department chairs to the document titled "Best Principles for Managed Care Medicaid RFP's," also produced by the Task Force on Community-Based Systems of Care for Children with Serious Emotional Disturbances, for reference on the principles of designing and participating within such systems of care.