Technical Assistance Resource Guide for the *Comprehensive Community Mental Health for Children and Their Families Program*

This Resource Guide provides information and resources to assist states and communities in developing, implementing, evaluating and sustaining systems of care to benefit children and youth with serious emotional disturbances and their families.

Center for Mental Health Services

Substance Abuse and Mental Health Services Administration

Department of Health and Human Services

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Preface

This document is a Resource Guide, providing information about community-based systems of care for children and adolescents with serious emotional disturbances and their families, such as those supported under the Federal ***Comprehensive Community Mental Health Services for Children and Their Families Program***. This Guide updates some areas of knowledge within the system-of-care field, provides a variety of suggestions about building successful systems of care, and identifies some basic key resources from the field.

Community-based systems of care are developed on a foundation of shared values and beliefs about how to best to meet the myriad needs of children and youth with a serious emotional disturbance and their families. The children and youth themselves, and the families and caregivers who care for them, hold the greatest interest in achieving successful outcomes and the community as a whole benefits when those outcomes lead to productive adult citizens who have overcome barriers and obstacles to reach maturity. This Guide provides detail to assist communities to identify and involve all appropriate partners, to build consensus about the vision and steps toward achieving the vision, and to build effective systems of care.

This Resource Guide also identifies various additional resources and sources of information that can be explored by interested communities. Many communities have worked for decades to build effective systems that care for the special needs of children and their families, and much of their learning has found its way into literature of all types, from professional journals to local newsletters. Communities will benefit by exploring resources identified in this Guide, while also seeking and using other system-of-care resources.

History and Philosophy of Systems of Care

The System of Care model is in many ways simple and direct, while in other ways quite complex. The first system-of-care definition was published in 1986:

> *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.*[1]

A system of care stands strongly on a foundation of *shared values* about how we – society – care for children with special needs and their families. A system of care is *community-oriented*, respecting community differences and linking together the many individuals and organizations interested in the well-being of children, adolescents, and their families. A system of care is *planned and deliberate*, carefully building an infrastructure to maximize the positive, effective impact of all community services. A system of care employs up-to-date knowledge about *effective practices*, respecting family choices, culture and abilities, and monitors its effect, *adapting constantly* to new information about impact and satisfaction. A system of care is a *system* – many components, each bringing something of value – wherein all participants hold a common goal of effective care for children and families.

Much has been learned as communities across the country worked to realize this definition of effective care. In the "Annual Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their families Program" (1998), prepared by Macro International, the following "hallmarks of the system of care approach" were presented:

- ☐ The mental health service system is driven by the needs and preferences of the child and family, using a strengths-based perspective.
- ☐ Family involvement is integrated into all aspects of service planning and delivery.
- ☐ The locus and management of services are built on multi-agency collaboration and grounded in a strong community base.
- ☐ A broad array of services and supports is provided in an individualized, flexible, coordinated manner and emphasizes treatment in the least restrictive, most appropriate setting.
- ☐ The services offered, the agencies participating, and the programs generated are responsive to the cultural context and characteristics of the populations that are served.

At the simplest level, this model promotes common sense and bringing community members, organizations and helping systems together to nurture all children and adolescents towards productive, satisfying adulthoods. A successful system of care, however, requires complex, long-term strategies, including: 1) commitment to a set of shared values across all system components; 2) a planned infrastructure to link and coordinate system functions; 3) a broad set of flexible service and support options; and 4) the full and meaningful participation of those children and families the system serves.[2]

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[1] Stroul, B.A. & Friedman, R.M. (Revised, 1994). A system of care for children and youth with severe emotional disturbances, (revised edition) Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

[2] For an explicit and detailed description of the System of Care model, see Stroul & Friedman.

The Program builds on a well-documented history of efforts to promote effective, community-based care for children and adolescents experiencing serious emotional disturbances (also known as severe emotional disturbances, mental illnesses or behavioral disorders) and their families. The Federal Child and Adolescent Service System Program (CASSP) established the first national public focus on community-based care of children and adolescents with serious emotional disturbances in 1983, eventually providing federal grants to all 50 states to begin developing effective service systems to better meet their needs. The key principles behind these state-level systems were: 1) involvement of the mental health authority for the State, county, and/or city; 2) collaboration of child-serving agencies on behalf of children and adolescents with a serious emotional disturbance and their families; 3) involvement of families as partners in planning, implementation and maintenance; 4) system support for interventions that are culturally relevant and competent; 5) individualized services for each child and family; 6) child and family assessments that are strength-based; and 7) delivery of a broad array of services in the home and community.

In 1989 the Robert Wood Johnson Foundation established the Mental Health Services Program for Youth and supported a set of communities as they built functional systems of care and reported on their development experiences. In 1992 Congress authorized SAMHSA to fund an initial set of communities as system-of-care development demonstration sites. Seven different cohorts of sites have now been funded under the CMHI over the past decade, resulting in 96 funded communities, including 2 territories and 10 American Indian/Alaska Native tribes or tribal organizations.

The Children's Mental Health Initiative provides an opportunity for communities to gain support to build necessary system-of-care components. To illustrate, communities can:

- Draw together system partners to deepen their shared understanding of the values foundation upon which the system of care is built;
- Establish or expand system infrastructure elements to link together all helpers within the community, promoting information dissemination, shared decision-making, collaborative partnerships, and effective care of children;
- Expand capacity across the full array of community-based services and supports needed by children and adolescents with serious emotional disturbances and their families;
- Promote system workforce development and increase the use of best practices (evidence-based and promising practices) across all aspects of care, supporting each direct care provider; and
- Learn to use finite resources more effectively, attaining improved outcomes for children with mental health needs and their families at the lowest viable cost.
- Empower families to have a decision making role in the care of their own children as well as the policies and procedures governing care for all children in the community, state, and nation.

As published recently in Building Systems of Care: A Primer:

> Building systems of care is a multifaceted, multilevel process. It involves making changes at state, local, and even neighborhood levels. It entails changes at policy and services delivery levels. Effective system builders are multidimensional, strategic thinkers. They recognize the complexities of system building and tend to be stimulated rather than discouraged by the process. They also are realistic. They recognize that system building takes time, is developmental, and proceeds in both a linear and circular fashion. They weigh strategically

> which aspects of system building to tackle at which developmental stage and guard against exhausting themselves by trying to take on ‘everything at once.’ They also constantly are looking for allies to engage in system building to spread the workload and maximize the resources.[3]

All efforts towards system building under this cooperative agreement can lay groundwork to sustain the resulting improvements far beyond the grant period, substantially reforming the community’s care of children with serious emotional needs and their families.

Target Population

The target population for the Program is all children and adolescents who have a diagnosable mental disorder (also called a “serious emotional disturbance”) that has negatively impacted their functioning at home, in school, and/or in the community for a year or more (or can be expected to last at least that long) and who are involved (or need to be involved) with two or more of the separate public service systems (including the education, child welfare, juvenile justice, health, mental health and/or substance abuse systems). A focus on children and adolescents who already manifest serious disorders assures that their needs are met in the most effective ways possible. The development of system-of-care components to care for this group of children and adolescents must also lead to system changes that benefit a wider set of children and families, including those with less serious needs, those involved with only one helping system, younger children, and members of sub-populations that are historically underserved or inadequately served by publicly funded systems. System of Care communities will work to serve children and adolescents in the target population, knowing that these efforts, along with building an enduring infrastructure, will positively touch additional children and families outside that population.

Additional Special Populations

Communities have selected to focus on building systems of care that serve any of several sub-populations of children, including:

- ❑ *Youth with co-occurring serious emotional disturbances and substance abuse disorders*;
    - ○ Evidence from the National Evaluation of this Program suggests that nearly 50 percent of all adolescents receiving services through funded systems of care have a co-occurring serious emotional disturbance and substance use disorder, suggesting that implementing communities should be aware of and seek to address the substance abuse treatment needs of any child or adolescent enrolled.
    - ○ Cooperative agreements funded under the Program are encouraged to use the “window of opportunity” during the pre-adolescent years to link the system of care with effective substance abuse prevention interventions for children identified with a serious emotional disturbance, such as those promoted through he National Registry of Effective Programs and Practices (NREPP) of SAMHSA’s Center for Substance Abuse Prevention. (See www.samhsa.gov.) While dollars under this Program will not be used to purchase substance abuse treatment

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[3] Pires, S.A. (2002). Building systems of care: a primer. Washington, DC: National Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center (pg. 10).

    services, the successful system of care must address these needs when they co-occur with serious emotional disturbances.

- *Infants and young children with serious emotional disturbances*;
    - Infants and young children, birth to age 5, may experience treatable serious emotional or behavioral disturbances but these needs are often ignored and/or inadequately addressed. System-of-care linkages to health care, child care, and pre-school providers for children this age are planned and deliberate.
    - Cooperative agreements funded under the Program are encouraged to propose systems of care that effectively serve children from birth to age 5, as a focus of system development or included as part of a larger effort to serve children from birth to adulthood.
- *Young adults with serious emotional disturbances*;
    - Young adults, particularly those 18-21, experiencing a serious emotional disturbance may be inadequately served in both the child and adult mental health systems, and linkages and coordination between those two systems are not routine.
    - Cooperative agreements funded under the Program are encouraged to propose systems of care that effectively deliver services to young adults through increased coordination and the development of community supports among all helping systems.

Youth involved with the Child Welfare System.

- There is clear evidence that youth in the foster care system are at greater risk for the development of serious emotional disturbances. Linkages with child welfare agencies are critical if mental health systems of care are to expand impact and create a broader approach to service delivery.
- Many Program communities have proposed service delivery models that incorporate child welfare systems and agencies.

Youth involved with the Juvenile Justice System.

- Estimates suggest that between 60-80% of youth in the juvenile justice system already experience significant mental health challenges, many of these qualifying as a youth with a serious emotional disorder. In addition, involvement in the juvenile justice system serves as a predictor variable for future mental health issues.
- System of care communities have already begun to document preliminary evidence indicating that this approach not only improves mental health outcomes, it also reduces recidivism and increases functioning at school. Communities are therefore creating more system of care models that link directly with the juvenile justice system, developing working partnerships to provide adequate service delivery to this population.

Overarching Goals

The primary goals for the CMHI Program are to:

- Expand community capacity to serve children and adolescents with serious emotional disturbances and their families;

- Provide a broad array of effective services, treatments and supports;
- Create a care management team with an individualized service plan for each child;
- Deliver culturally and linguistically competent services for racial and ethnic populations represented in communities; and
- Promote full participation of families and youth in service planning and in the development of local services.

Expand community capacity: Currently, many communities lack adequate capacity across a wide range of community-based services and supports to care for a substantial portion of the population needing care. Service and support capacity expansion occurs as the result of deliberate and careful planning within the community, involving all relevant partners, including state-level decision-makers.

A broad array of services and supports: Effective care is highly individualized for each child and family, requiring a wide set of service and support options to be available within the community. Further, all options are designed for flexible application to each child and family, in response to their strengths and needs. Flexibility may be obtained by offering services at multiple locations and across all hours of family life (including evenings and weekends), by utilizing service and support providers who represent broad diversity in preparation and life experience, and by many other locally-determined methods.

Care management team and individualized service plan: Children with complex and challenging needs are best served when a team is formed around the child to plan and monitor care. Such teams are unique for each child and family, including professional and non-professional helpers, as well as caregivers and others important in the child's life, and they work in partnership to identify the best options for effective care. A team's work is guided by an individualized service plan, created uniquely for each child and family, and changed as often as necessary to reflect changes in the child, the family, and/or their circumstances. Such plans should treat the family as a unit and seek to coordinate service efforts across all family members.

Culturally and linguistically competent services and supports: Communities contain diversity across many racial, ethnic, cultural and economic groups, and children and adolescents of all backgrounds and experience, or are at risk of, serious emotional disturbances. Effective systems of care are prepared to learn about community diversity and respond with care that respects and is sensitive to the traditions, values and beliefs of each child and family, with services and supports accessible in languages other than English, as appropriate to each community.

Full participation of families and youth: No other goal is more important to system-of-care development than to create effective and positive partnerships among helpers and caregivers of children and adolescents with serious emotional disturbances. Advances in understanding of brain development and functioning demonstrate that many serious emotional disturbances are based on biological processes, requiring care strategies with biological or medical elements. A system of care strives to view parents and other caregivers as the child's "best experts", positively engaging them in all aspects of care planning, delivery and evaluation about their child and supporting their efforts to successfully raise their own child. Likewise, children and youth are invited and encouraged to participate in guiding their own care to the fullest extent possible, considering each child's age, development, and clinical needs. The importance of family-driven care and the inclusion of youth as part of decision making is a hallmark of this approach and are demonstrated in all aspects of the Program's model.

Infrastructure Development

The Program supports the development of 16 key administrative structures and procedures in its implementing communities. The importance of infrastructure development in building systems of care cannot be overstated – each of these structures and procedures plays an important role in effective system functioning, as explained below. Planners will want to pay substantial attention to items in this list, taking advantage of already existing elements, perhaps adapted for particular populations, and determine how to create elements not yet in place.

Key Administrative Structures and Procedures

- ***Establishment of governance body*** refers to a group of individuals with the authority to make policy decisions for the system of care. The group includes representatives of the public entity that is awarded the Federal funds and also representatives of collaborating state or community child-serving agencies (such as education, health, child welfare, juvenile justice, mental health, and substance abuse), family members, youth, and other community representatives, including representation from racial or ethnic minority populations. This governing body may be organized as a board of directors of a newly incorporated system of care or as a committee, task force, workgroup or other such decision-making body of an existing human service agency. This body develops and upholds formal agreements and memoranda of understanding between the collaborating child-serving agencies, including those from all relevant political subdivisions of the State. It also holds the system of care accountable for meeting high standards of care, including standards for cultural responsiveness and family involvement, as well as standards of practice that have been shown to be effective through research and evaluation studies.

- ***Systems integration*** is the organization and coordination of resources available through Federal, State, and local human service systems responsible for serving children with serious emotional disturbances and their families. Strategic planning, consolidation of funding streams, and policy formation are examples of tools that promote integration efforts.

    - As part of systems integration, the Program requires that the local system of care develop formal relationships with the State, tribal, or territorial mental health authority to increase the likelihood of sustaining the local community-based system of care, and also to provide an effective system-of-care model that can be replicated across the State. All relevant State agencies, in collaboration with the State child and adult mental health authorities, will collaboratively implement the local system of care approach through statewide policies and fiscal initiatives to increase the likelihood of sustainability. Local system of care development should generally be described in the goals of the State's Community Mental Health Services Block Grant Plan, submitted under Public Law 102-321. The State mental health authority also should ensure that the local system of care is a Medicaid provider, as required in Section 561(a)(2)(b)(2) of the Public Health Service Act.

    - In addition, under the Program states or communities are asked to provide a plan on how the State mental health authority intends to replicate the system-of-care model across the State. The replication plan from the State mental health authority may include approaches at various levels of effort, including replication of the system-of-care model:

  - During the 6 years, through a phased and strategic approach across one or more counties within the State.
  - After the 6 years of Federal funding; and

- ***Interagency collaboration*** is defined as formal arrangements between child-serving agencies that describe planning, provision, and evaluation of the broad array of services. ***Child-serving agencies*** include those that deliver services and supports in the areas of mental health, education, child welfare, child protection, juvenile courts, juvenile corrections, primary health care, and specialty services such as substance abuse treatment and prevention, vocational counseling, and rehabilitation. They are located in the community or have the capacity and authority to provide services in the community. Formal arrangements for collaboration must be stated clearly in memoranda of agreement, policy manuals, board minutes, or other documents shared among the agencies. These documents should specify the role(s) that each agency plays in the system of care. At a minimum, they should specify each agency's financial or in-kind contribution, official representation in the governance structure, and participation in strategic planning, delivery of relevant services, and evaluation. They also should specify whether the agency is a local or State entity and indicate any special requirements that must be met for participation of the local or State agency. A staff person within each entity should be designated to implement the above arrangements.

- ***Service integration*** refers to the efforts of a care manager, together with an individualized care team, to organize and coordinate multiple services and arrange for their efficient and effective delivery to each child with a serious emotional disturbance and the child's family. An individualized service plan is a tool that the care manager and the individualized care team use for service integration. Service integration takes place on behalf of each child and family, and the system must be organized to support integration activities. One goal of service integration is to eliminate and avoid duplication of efforts, especially when services are delivered through collaborating child-serving agencies. More important, however, is the goal to give each child and family a unified, efficient, and supportive service experience.

- ***Wraparound process*** is defined as an approach to care planning and service provision that organizes and manages the delivery of multiple services, treatments, and supports to a child and the child's family in ways that are flexible, individualized, strengths-based, family-driven, culturally responsive, and effective. Such services, treatments, and supports are aimed at meeting the unique needs of each child and family and are driven by the goals of the child and family. Wraparound processes are organized around all key life domains (home, school, and community living). Some services may be delivered through formal agency procedures, while others may be delivered through informal arrangements in the community. Like the individualized service plan, the wraparound process is a powerful tool for service integration.

- ***Flexible funds*** are service monies that can be used for service and support activities that are outside traditional funding streams and, when purchasing those items are non-reimbursable by State and Federal fund streams. For example, flexible funds may be used to pay for horseback riding lessons for a child with a serious emotional disturbance who expresses a strong interest in this recreational activity, if this activity has the potential for a positive therapeutic effect on the child. Generally, the individualized care team determines when it is appropriate to use flexible funds for an individual child and family, and the system maintains accountability procedures regarding the use of those funds.

- ***Care review*** is a deliberate process used by a designated interagency group to examine how well services are being delivered to individual children and their families. The purpose of such examination is to develop recommendations for improving the system adequacy, appropriateness, quality of service and the procedures for delivery of services. Special attention is given to how well each child-serving agency is contributing to meeting the individual needs of children. Communities often use experienced supervisors and family members from child-serving systems to conduct ongoing care review procedures.

- ***Access*** refers to the ease with which eligible children and their families are able to receive needed services. Children and their families are provided with clear and comprehensible eligibility criteria. Procedures for determining eligibility and entry into services are efficient and timely, with limited paperwork demands. Services are located within distances that make it relatively easy for children and families to reach and at times flexible enough to meet the needs and schedules of families.

- ***Financing approach*** refers to the community's capacity to fulfill the non-federal match requirements and to obtain necessary funding to maintain and enhance the system of care beyond the 6-year Federal funding period of this Program. Specifically, it refers to: (1) funding for services from collaborating State and community child-serving agencies; (2) access to existing categorical service funds from public and private sources for which children with a serious emotional disturbance and their families are eligible, such as Medicaid, the Child Health Insurance Program, and private insurance; and (3) other public and private funds to support system-of-care activities and structures, other than services such as training, research, and equipment. A system of care uses financial resources strategically to accomplish its vision, values, and priorities, ensuring that "the program drives the dollars." Grant communities will consider what approach or combination of approaches best supports the types of development planned within the system of care, engaging multiple fund streams to meet the non-federal match requirements and to sustain system development after the grant ends. The system of care also implements methods to assure fiscal accountability to each funding source.

- ***Workforce development*** refers to the strategies used by the system of care to ensure that there are adequate numbers of staff with the attitudes, knowledge and skills to successfully manage the system of care and deliver the services to children and families, including traditional human resource activities (e.g., recruitment; retention; incentives) and staff development (e.g., training; educational supports; supervision). Training strategies may include in-service educational opportunities such as seminars, workshops, institutes, and continuing education units. Family members and/or staff may be given scholarships or time-off awards to participate in formal educational experiences such as certification programs and professional degree programs, adding competencies to system care. Workforce development partnerships with higher education institutions in the community are encouraged, particularly those that help to ensure that the workforce reflects the diversity of the community.

- ***Support from community leaders*** is defined as the endorsement of system-of-care goals and activities given by community leaders (e.g., judges, mayors, clergy, business executives, presidents of educational institutions), including leaders from racial and ethnic minority populations. Such endorsements may be given through public statements, financial contributions, or direct representation in the governing body of the system of care. Ongoing activities to inform and involve community leadership are expected in effective systems of care.

- ***The clinical network*** is defined as the set of services, treatments, and supports that exist and are available within the system of care to serve children with a serious emotional disturbance and their families. Each awardee is urged to enhance and develop its clinical network to the highest possible level of quality, aiming to serve as a model of system reform in the State. Awardees should implement to the greatest possible extent Federal or professional practice standards and guidelines for the delivery of children's mental health services. These standards and guidelines may focus on the delivery of specific clinical interventions, and they may address the delivery of system-of-care services such as intensive care management, therapeutic foster care, and home-based crisis intervention. Awardees are required to include in their clinical network one (or more) evidence-based service or treatment that has been shown to be effective in research studies.

- ***The administrative team*** is the group of individuals responsible for developing, implementing, and managing the system of care within this project. Specifically, this team will:

  - Develop a strategic plan that includes a component for social marketing, local-level evaluation, and sustainability.
  - Coordinate services delivered through collaborating child-serving agencies;
  - Budget, manage, and expend service funds for required services;
  - Integrate funding streams, as appropriate;
  - Award and manage contracts for service delivery, training, technical assistance, evaluation, and social marketing, as appropriate;
  - Use findings from the National Evaluation and any local evaluation to shape future program direction, decisions about practices and policies that work, and to develop a quality improvement plan;
  - Implement care review procedures;
  - Monitor the extent and quality of implementation of individualized service plans;
  - Examine the extent to which service decisions for children utilize the least restrictive, most normative, and safest environments that also are clinically appropriate, focusing especially on decreasing the need for out-of-home and out-of-community placements;
  - Monitor the degree to which care management and other services enhance the strengths, resilience, protective factors, and well-being of children and families;
  - Comply with the rules and regulations for electronic exchange of information and for confidentiality of care records, as required by the Health Insurance Portability and Accountability Act (HIPAA).

- ***Training capacity*** is an important element of workforce development, defined as the ongoing strategies used by the system of care to ensure that there are adequate numbers of staff with the attitudes, knowledge and skills to successfully manage the system of care and deliver the services to children and families. Adequate training capacity may be achieved by budgeting specific dollars to hire trainers and consultants with specific expertise in areas such as system leadership, fiscal management, personnel management, implementation of clinical interventions and the wraparound process, quality improvement, and evaluation. Systems of care strive to include parents and other caregivers, as well as youth, in training activities, both as participants and trainers. Systems of care seek and utilize cross-system training strategies, coordination of training resources (e.g., IV-E training resources), and maximum opportunities for interagency staff and the children and families they serve to teach each other.

- ***Performance standards*** are defined as the criteria or benchmarks that are established to measure the degree to which the system of care meets quality and effectiveness goals. These goals may describe areas such as access, capacity, clinical outcomes, service provision, family and youth satisfaction, infrastructure development, workforce development, and others. Child and family outcomes are the most important system of care standards. In addition, system-level outcomes (e.g., reducing out-of-home placements) and process outcomes (e.g., increasing the number of front-line and supervisory staff active in collaboration activities) must also be included as part of the evaluation and monitoring functions of the system of care.

- ***Management information system*** (MIS) refers to a computerized system for the electronic collection, storage, management, and exchange of information within the system of care. At a minimum, the MIS should be used to record the type, amount, and cost of services delivered to each child and family in the system of care. These services should include those reimbursed by Medicaid and also those covered by cooperative agreement funds and by any other State or private funding streams. There should be a close correspondence between the services delivered as part of the individualized care plan and the services recorded in the MIS. As much as possible, the MIS should be integrated across the collaborating child-serving agencies and be used as a tool for the coordination of service delivery. In addition, the MIS should have the capacity to integrate child and family outcome data from the National Evaluation. The MIS procedures must be compliant with HIPAA specifications.

Key Activities and Concepts

Systems of care for children with a serious emotional disturbance and their families emphasize a set of key activities and concepts that are generally addressed by communities under the Program. System-of-care planning processes will lead to the development of strategies to promote each of these activities and concepts.

Delivery of Clinical Interventions. The system of care must ensure that children with a serious emotional disturbance have access to the most effective clinical interventions. A ***clinical intervention*** refers to a service, treatment, or therapy that is used to assess or treat a specific diagnosable emotional, behavioral, or mental disorder, or a combination of co-occurring disorders, and is delivered by trained and qualified personnel. The system of care should, at a minimum:

1. Implement one (or more) *evidence-based intervention*, defined as an intervention that has been scientifically studied and found to produce positive outcomes for children and families. Typically, an evidence-based intervention includes:

- ❑ A written manual that serves as a procedural guide for implementing and replicating the intervention. The purpose of the manual is to ensure adherence to a specific set of intervention procedures referred to as the *intervention protocol.* Manualized care promotes the delivery of an *effective intervention* that results in positive individual outcomes that are better than the outcomes from conventional, untested interventions, or better than the absence of any intervention and a *quality intervention*, delivered efficiently and producing high satisfaction and acceptability from the child and family.
- ❑ Several research studies that, as a set, produce reliable, valid, and generalizable findings about the effectiveness of the intervention. These findings demonstrate that the intervention results in consistent positive outcomes across children and/or for a specific population for whom the intervention was intended (e.g., children experiencing major depression). Findings also show that the outcomes of the intervention can be replicated consistently across population groups (e.g., racial or ethnic) or in different settings (e.g., rural, urban).
- ❑ Specification of a clinical population for which the treatment applies, such as children with depression, attention deficit/hyperactivity disorder, or oppositional defiant disorder.[4]

2. Ensure that procedures for diagnosis and treatment planning match the individual and unique mental health needs of the child with the most appropriate treatment or combination of treatments.
3. Encourage implementation of state-of-the-art, community-based treatment methodologies.
4. Make necessary adaptations to innovative evidenced-based interventions for the target populations, particularly for racial and ethnic minority populations in the specific communities served by the program.
5. Conduct clinical assessments in a manner that recognizes gender and cultural differences in the diagnosis of overt behaviors and the evaluation of presenting problems.
6. Address the training needs of clinicians in several areas, including the delivery of evidenced-based treatments and appropriate application of DSM-IV diagnostic categories.

Delivery of Care Management Services. Care management services (also known as care coordination or case management), tailored to the needs of each individual child, are required for all children and adolescents who are offered access to the system of care under this Program. ***Care management*** represents the procedures used by a trained service provider to access and coordinate services for a child with a serious emotional disturbance and the child's family. These procedures establish an identifiable point of accountability between the child and family and all helping systems.

The system of care will provide each child in the target population with a level of care management appropriate to the child and family's strengths and needs. Care management services should, at a minimum:

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[4] For more detailed resources, see the National Registry of Effective Programs and Practices (NREPP) (at the www.samhsa.gov web site.), the *Blueprint for Change: Research on Child and Adolescent Mental Health* (National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; at http://www.nimh.nih.gov/child/blueprint.cfm.), and the *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 1999).

1. Unify and coordinate services provided to the child and the child's family, including those specified in the individualized service plan and any other services or supports.
2. Establish eligibility of the child and the child's family for financial assistance and services under Federal, State, and local programs, and document that such services and supports are received.
3. Reassess the needs of the child and the child's family at regularly established intervals, and modify the individualized service plan accordingly.
4. Provide the family with information on progress made toward the objectives in the individualized service plan.
5. Create intensive or therapeutic care management services for children with the most severe emotional disturbances at a ratio of no more than 10 children for every one intensive care manager.
6. Create care management services for children with a serious emotional disturbance whose needs are less complex than those with severe needs, but who still require regular monitoring or coordination of service delivery. The ratio of assigned children to this type of care manager should be no more than 15 to one.

Development of an Individualized Service Plan. Each child or adolescent served within systems of care under the Program must have an individualized service plan developed by an interagency team that includes the child's parents or caregivers and, unless clinically inappropriate, the child. The ***individualized service plan*** defines in writing the procedures and activities that are appropriately scheduled and used to deliver services, treatments, and supports to a child and the child's family. These procedures and activities must fit the unique strengths and needs of the child and the child's family. The group that assists the care manager, family members and child to design and implement the individualized service plan is the ***individualized care team***, comprised of representatives from child-serving agencies that provide services to the child and the family, as well as informal but significant individuals in the community who relate closely to the child and family, such as a minister, friend, or community leader.

Development of the *individualized service plan* must include:

1. An emphasis on identifying and building upon the existing strengths of the child and the child's family.
2. Coordination with services available under parts B and H of the Individuals with Disabilities Education Act (IDEA), including consistency and coordination with the Individualized Education Plan (IEP).
3. Coordination with services available through the U.S. Department of Health and Human Services, Administration for Children, Youth and Families' Family Preservation and Support Program (Title IV-B, Subpart 2, Social Security Act).
4. Inclusion and implementation of the following components of the plan:

    a. Identification of existing strengths of the child and the child's family and how the strengths will used in support of the individualized plan;
    b. Description of the service and support needs;
    c. Development of objectives that build upon the existing strengths and meet the needs of the child and the child's family;
    d. Description of methodologies for meeting these objectives, including all necessary services and supports;
    e. Provision of non-mental health services, as appropriate; and,

   f. Designation of the lead agency responsible for care management services.

5. Regular review of the appropriateness of services in the individualized service plan, and revisions when necessary, but at least quarterly (every 90 days).

Family driven and youth-guided care. Family-driven means families have a decision making role in the care of their own children as well as the policies and procedures governing care for all children in the community, state, and nation. This includes choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; and determining effectiveness of all efforts to promote the mental health of children and youth.

Guiding Principles

1. Families and youth have accurate, understandable, and complete information necessary to make choices for improved planning for individual children.
2. Families and youth are organized to collectively use their knowledge and skills as an engine for systems change.
3. Families and youth embrace the concept of sharing decision-making and responsibility for outcomes with providers.
4. Providers embrace the concept of sharing decision-making authority and responsibility for outcomes with families and youth.
5. Providers take the initiative to change practice from provider-driven to family-driven.
6. Administrators allocate staff, training, and support resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families.
7. Peer support reduces isolation and strengthens family and youth voice.
8. Community attitude change removes barriers created by stigma.

Conditions that exist in family-driven care model

1. Administrators and staff actively demonstrate their partnerships with all families and youth by sharing power, resources, authority, and control with them.
2. Family and youth experiences, their visions and goals, their perceptions of strengths and needs, and their guidance about what will make them comfortable steer decision making about all aspects of service and system design, operation, and evaluation.
3. Meetings and services happen in culturally and linguistically responsive environments where family and youth voices are heard and valued, everyone is respected and trusted, and it is safe for everyone to speak honestly.
4. Families and youth have access to useful, usable, and understandable information and data, as well as sound professional expertise so they have good information on which to base the choices they make.

Youth-Guided. Activities to support active youth participation include:

- ❑ Designation of an individual to serve as *youth coordinator* in the system of care. Duties of the youth coordinator should, at a minimum, include: helping to form an organized group among youth receiving services; advocating for youth who are receiving services; reaching out to eligible youth who are not receiving services; and representing youth on the governance body.

Cultural and Linguistic Competence. Each child and family served by a system of care comes with unique strengths, needs and circumstances, including what they believe, what they value, and the traditions they choose to practice. Cultural and linguistic responsiveness is demonstrated when individual service providers possess the attitudes, knowledge, and skills to effectively serve children with a serious emotional disturbance and their families coming from racial or ethnic minority groups in the community. The attitudes, knowledge, and skills of all system helpers collectively reflect system respect for community diversity and contribute to the well being of all children and families. Cultural and linguistic responsiveness also refers to the policies and practices of the system of care that have a positive effect on the well being of all children and their families.[5]

Cultural competence requires that organizations:

- ☐ Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- ☐ Have the capacity to: 1) value diversity, 2) conduct self-assessment, 3) manage the dynamics of difference (through tools such as negotiation, mediation, or conflict resolution), 4) acquire and institutionalize cultural knowledge, and 5) adapt to diversity and the cultural context of communities served.
- ☐ Incorporate the above in all aspects of policy-making, administration, practice and service delivery, and systematically involve consumers, families and communities.

Communities supported under the Program generally implement the following activities, designed to enhance the cultural responsiveness of a system of care:

1. Compliance with Title VI of the Civil Rights Act.
2. Application of cultural competence standards, as suggested in documents such as the Culturally and Linguistically Appropriate Standards (CLAS) in Health Care, published by the U.S. Department of Health and Human Services, or those included in CMHS's "Cultural Competence Standards" publication.
3. Identify and address disparities in access and utilization, quality of mental health services, availability of effective clinical interventions, clinical and functional outcomes, satisfaction with services and supports, and other system-of care outcomes of children, youth and families from culturally and linguistically diverse groups.
4. Incorporation of culturally appropriate practices in each individualized service plan, such as: using the preferred language of the child and the child's family during service delivery; nurturing the strengths, customs and traditions of the child and the child's family that reflect their cultural or religious heritage; and respecting behaviors and beliefs of the child and the child's family that are culturally accepted – in their culture.[6]
5. Individuals from racial or ethnic minority groups in the community are invited and supported to participate meaningfully in activities of such system-of-care entities as the governing body, administrative team, care review group, and individualized care teams.

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[5] For a detailed discussion of cultural competence in a system of care, see Cross, T.L., Bazron, B.J., Dennis, K.W., and Isaacs, M.R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center; with two subsequent volumes in 1991 and 1998.

[6] For additional information, see "Planning for cultural and linguistic competence in systems of care for children and youth with social-emotional and behavioral disorders and their families," developed by the National Center for Cultural Competence, which can be found at http://gucchd.georgetown.edu/nccc/products.html.

Such individuals may serve as effective advocates for children and families from those cultural groups.

6. Provide evidence that the management plan, staffing pattern, project organization, and projected resources are appropriate and adequate for carrying out all aspects of the proposed project, including practice models that incorporate culture and language in the delivery of services and supports to diverse groups.
7. Expand services available through the system of care to include service providers reflecting the cultural and linguistic diversity of the community.
8. System-of-care services are (1) planned in the cultural context preferred by the child and the child's family, and (2) provided without discrimination against the child or the child's family on the basis of race, religion, national origin, gender, sexual orientation, disability, or age (i.e., for the child, age 21 years or younger).

Racial or ethnic minority groups, as used in this Program, refer to the four primary racial or ethnic groups that have been found nationally to be underserved in the area of health care, including the African American, Hispanic, American Indian and Alaska Native, and Asian American and Pacific Islander groups. These groups also include underserved immigrant and refugee groups who have recently arrived in the United States from other countries of the world, as identified by local community leaders.

Early Intervention. A system of care that effectively responds to the needs of infants and preschoolers with a serious emotional disturbance and their families must include, at a minimum:

1. Appropriate assessments (designed for use with infants and young children) for the identification of infants and preschoolers with a serious emotional disturbance.
2. Collaborative arrangements with the primary health care sector (e.g., family physicians, pediatricians, public health nurses) to provide linkages between early health care and the treatment of mental health needs. These arrangements may include a system for referrals to system-of-care services for children and their families and/or guidelines for treatment of these children, especially when a serious emotional disturbance co-occurs with a chronic illness.
3. Integration of services provided through the childcare provider, early childhood education, and infant and early childhood public health systems. Such integration should occur across Federal and state programs, including Head Start, Early Head Start, and Healthy Families.

Elements of Sustainability

Communities supported under this Program are pursuing long-term system-of-care development. From the beginning, planning aims towards sustaining all gains made under the Program after Federal and other grant funds have ended. Ten years of experience with this Program in multiple communities has led to the identification of ***key elements of sustainability*** to which grant communities attend, in planning, implementation, and evaluation.

- ❑ Vision

Local project leaders set the *vision* for system-of-care development, describing how the system should be functioning when fully developed, and then monitor actual growth against the vision on a recurring basis, also evolving the vision as needed. The vision guides development at all levels, at all times, which requires deliberate strategies to both disseminate and update the vision. Effective system-of-care communities keep the vision alive through active discussion and ongoing consideration of its local implications.

- ❑ Results Orientation and Key Indicators of Success

The Program seeks *measurable improvements* in the experience of children with serious emotional disturbances and their families – these are the results that matter. While it is also important to seek measurable improvements in system functioning, the primary desired results are found in the experiences of children and families and the quality-of-life improvements they attain as the result of system activities. Grant communities will be oriented towards constant improvement, establishing the intended outcomes and *key indicators of success* that demonstrate improvement, monitoring progress across those outcomes and indicators, and utilizing evaluation findings to constantly adjust program operations. In the simplest terms, when planned strategies do not obtain the intended outcomes (at the individual child level or the system level), planners use that information to change the strategies being employed.

- ❑ Strategic Financing

A system of care *uses financial resources strategically* to accomplish its vision, values, and priorities, ensuring that "the program drives the dollars." Some communities will choose to shift dollars from traditional uses to more flexible, community-based activities; some will seek to maximize the use of major funding streams (e.g., Medicaid, Title IV-E); some will implement changes in how dollars are allocated to services, employing strategies such as pooled funding, capitation or case rate financing, or family budgeting approaches. Grant communities will consider what approach or combination of approaches best supports the types of development planned within the system of care, engaging multiple fund streams to sustain system development after the grant ends.

- ❑ Key Champions and Leadership

System-of-care communities seek and support *leadership* from across the community, including but not limited to service system leaders. From conception through implementation, *key champions* are likely to emerge, serving both to broaden community support and to increase understanding of community-based care of children with emotional disturbances and their families. At different stages of system development, different types of leadership may be required, with leaders reflecting the major strategies needed at each stage. Successful grant communities will plan to identify and develop leadership among all stakeholders in the system of care, with special attention given to leadership from family members and youth served within the system. It is appropriate for system-of-care planners to nurture leadership through deliberate program activities.

- ❑ Family and Youth Advocacy

In the Program model, everyone connected with the system serves as an advocate, and a critical area of advocacy is support for the meaningful participation of children and adolescents and their families. This model rebalances the power within helping systems to ensure that families are equal partners in the care of their children and to support youth to be actively involved in their own care and recovery. Primary caregivers of children are considered to be the "best experts" regarding their children. System-of-care communities support the development of *family and youth advocacy*, linking with family and youth advocacy organizations and offering training that includes caregivers and youth, both in giving and receiving training. Systems provide tangible supports, such as transportation, translation, or childcare assistance, to enable caregiver and youth participation. Beyond such supports, communities strive to recognize the multiple roles that can be played by families, caregivers and youth, including, but not limited to: guiding care of their own children; participation on steering committees; delivering services to other children and families, such as care management, mentoring, and peer support; evaluation activities, such as gathering data, determining the meaning of data gathered, and reporting to the community; and serving in key system roles, based on competencies, credentials and experience.

- Community Support

The system of care is not separate from the *community* but is an integral part of the community as it responds to the needs of community members. Community members are educated by the system and given avenues for involvement in support of the ongoing care of children and their families. Leaders and others active in the system of care constantly educate and involve additional community members to create a climate that nurtures community-based care of children and their families. The community is recognized as the repository of everything needed to successfully care for children with special needs through advocacy, organization, and mobilization.

- Adaptability to Changing Conditions

The environment surrounding a system of care continues to change and evolve in response to, and regardless of, system activities, demanding *adaptability to changing conditions*. In particular, circumstances at the state level strongly impact local decision-making, yet local decision-makers may feel powerless to impact state circumstances. As circumstances evolve, systems of care look constantly for opportunities to put in place new policies and practices that lead to the vision becoming reality. When stressors press against the system, it finds ways to maintain the most necessary system functions. Change is expected throughout the life of this Program and beyond, and systems are prepared to respond.

- Strong Governance and Interagency Collaboration

Systems of care require *strong governance*, which is exploring, deciding, and monitoring policy and implementation. Governance is necessarily an *interagency* process because various components of child and family care and the respective resources are lodged in different agencies, as defined by Congress and State legislatures. Likewise, governance is an important function in which children and families affected by system activities must participate, fully and meaningfully. It is important for local governance bodies to consider: 1) the extent and limitations of its authority; 2) its responsibilities; 3) its credibility in the community; 4) its capacity to govern; 5) its shared liability; and 6) its representation of all appropriate system stakeholders. Separate agencies must also work together to build trust and communication so that the strengths and voices of all stakeholders can impact system success. System planners will regularly revisit these and other questions to keep interagency governance processes representative and relevant.

- Political and Legislative Advocacy

This Program is aimed at developing systems of care within communities that can then demonstrate their methods of success to the broader systems in which they operate. Just as the political climate impacts each community’s ability to implement systems of care, such local systems can and do impact the political climate, demonstrating how to effectively care for children with challenging needs and keep the public cost of care within manageable limits. Through *political and legislative advocacy*, each State legislature is informed regarding project activities and outcomes, using grantee experience to guide relevant legislation in support of the system of care approach.

- ☐ Clear Sustainability Plan

Each of these sustainability elements (and others, as determined locally) should be addressed in a long-term *Sustainability Plan*. The plan should begin when the project begins and continue to grow throughout the project's life. Gains made under this Program will not survive without deliberate efforts in each community to support and institutionalize necessary changes in practice, policy, and oversight.

Evaluation Details

Implementing communities under this Program are expected to comply with the requirements of the National Evaluation, conducted under contract by SAMHSA, and participate in the collection of descriptive and outcome data.

Applicants agree to participate in the development and implementation of quality improvement methods and to work with the Project Officer and other contractors to identify benchmarks (i.e., targets/goals) that will determine project progress. These benchmarks will be consistent with system-of-care principles and the outcomes contained in the President's New Freedom Commission Report. Examples include movement towards a family driven system of care, the reduction of ethnic, racial and geographic disparities in care, and improvements in functional behaviors.

Implementing communities will ensure that adequate resources are included for local level evaluation, including analysis of ethnic, cultural, and linguistic disparities in service development, and evaluation of strategic plans that focus on long-term sustainability.

Regular training and technical assistance sessions will be conducted on-site, during awardee meetings, and at other scheduled times throughout the 6-year Federal funding period for implementing communities under this Program. Evaluation staff and other system-of-care staff will be asked to participate in these training and technical assistance sessions.

To meet the requirements of the National Evaluation, communities will be required to:

1. Adhere closely to the design of the National Evaluation.
2. Implement procedures for collection, entry, management, and storage of data.
3. Comply with National Evaluation data collection and reporting requirements.
4. Transmit data to the National Evaluation contractor on a scheduled basis.
5. Report evaluation findings on the local system of care to the stakeholders of the system of care, including family members, personnel of collaborating child-serving partner agencies, clinical staff, members of the governing body, and others.
6. Use evaluation findings to inform system-of-care development efforts, including improvement of management procedures, adoption of new system and service policies, attainment of new sources of public and private financing, and others.
7. Involve youth who are receiving services and their family members in the implementation of the National Evaluation.

8. Obtain written assurances from each participating agency indicating a willingness to cooperate with the required activities of the National Evaluation.
9. Hire at least two full-time equivalent (FTE) evaluation staff. One FTE must have an earned Ph.D. in public health, psychology, social work, or other relevant area of human services. At least one of the full-time evaluation staff should have an office located in the awardee community. Evaluation staff must have knowledge of and experience with coordinating and implementing longitudinal data collection activities, including tracking individuals, data management, data analysis, basic quantitative and qualitative evaluation methods, and report writing.
10. Participate in an annual 2- to 3-day site visit conducted by the National Evaluation contractor to assess development of the awardee's system of care. During this annual site visit, structured interviews will be conducted with persons representing service recipients and their families, service providers, partner systems and agencies (from management to front-line service delivery), and evaluation staff. Applicants must secure an agreement from each collaborating child-serving agency that staff will be available for and participate in the site visits.
11. Obtain approval from an Institutional Review Board (IRB) associated with the system of care to perform the data collection strategies required by the National Evaluation.

In addition, implementing communities are encouraged to enhance the National Evaluation with their own local evaluation activities. These local evaluation activities help ensure that the unique needs for system-of-care development within each community are being met. Data and findings from local evaluation efforts do not need to be transmitted to the National Evaluation contractor, unless arrangements are made for a special study that can be valuable for the development of systems of care across the nation. However, critical findings from local evaluation efforts may be reported in cooperative agreement re-applications and quarterly reports.

Definitions

Best Practice: *Best practices* are practices that incorporate the best objective information currently available from recognized experts regarding effectiveness and acceptability. Best practices include, but are not limited to, *evidence-based* (defined as practice knowledge "obtained through carefully implemented scientific methods about the prevalence, incidence, or risks for mental disorders, or about the impact of treatment or services on mental health problems"[7]) and *promising approaches* (defined as practice knowledge supported by evidence of effectiveness through the experiences of key stakeholders, such as families and direct-care providers).

Catchment Area: A *catchment area* is the geographic area from which the functioning system of care will draw the target population to be served.

Community: Under this Program, *community* is any discrete geographic entity that is defined by an applicant. The scope and size of the community is left to State or local discretion. States and non-State applicants may choose to create systems in communities as small as a single school district or as large as a county or a group of contiguous counties. A State with a sparse

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[7] For a detailed discussion, see Burns, B. & Hoagwood, K. (Eds.). (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press.

population may wish to develop a system to cover the entire State, but it is expected that this will be the exception. The amount of funds requested by a community will be proportional to the number of children in the community, and communities must ensure that sufficient funds are requested and available to develop a comprehensive system of care with sufficient service capacity in the designated target community.

Cooperative Agreement: A *cooperative agreement* is a form of Federal grant. Cooperative agreements are distinguished from other grants in that, under a cooperative agreement, substantial involvement is anticipated between the awarding office and the recipient during performance of the funded activity. This involvement may include collaboration, participation, or intervention in the activity. HHS awarding offices use grants or cooperative agreements (rather than contracts) when the principal purpose of the transaction is the transfer of money, property, services, or anything of value to accomplish a public purpose of support or stimulation authorized by Federal statute. The primary beneficiary under a grant or cooperative agreement is the public, as opposed to the Federal Government.

Cost Sharing or Matching: *Cost-sharing* refers to the value of allowable non-Federal contributions toward the allowable costs of a Federal grant project or program. Such contributions may be cash or in-kind contributions. For SAMHSA grants, cost-sharing or matching is not required, and applications will not be screened out on the basis of cost-sharing. However, communities often include cash or in-kind contributions as evidence of commitment to the proposed project.

Family Involvement: *Family involvement* refers to the identification of, outreach efforts to, and meaningful engagement of diverse families ("diverse" is an inclusive term to describe families of various races, ethnicities, gender orientations, socioeconomic backgrounds, and family structures reflective of the community being served) receiving services from the proposed system-of-care community and of the target population, so that their collective experiences and perspectives meaningfully drive the planning, implementation, and evaluation of the system of care.

Family Member: Families who have children, youth, or adolescents with a serious emotional disturbance are organized in a wide variety of configurations, regardless of social or economic status. Families may include biological parents and their partners, adoptive parents and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, kinship caregivers, friends, and others, *as defined by the family*. A family may include any primary caregiver for a child, youth, or adolescent with a serious emotional disturbance, and the primary caregiver may receive significant support from extended family members.

Family-run Organization: A *family-run organization* is a private, nonprofit entity that meets the following criteria: 1) its explicit purpose is to serve families who have a child, youth, or adolescent with a serious emotional disturbance (an emotional, behavioral, or mental disorder, age 0-18, or to age 21 if served by an Individualized Education Plan); 2) it is governed by a board of directors containing a majority (at least 51%) of individuals who are family members; 3) it gives preference to family members in hiring practices; and, 4) it is incorporated as a private, nonprofit entity (i.e., 501(c)3 status).

Fidelity: *Fidelity* is the degree to which a specific implementation of a program or practice resembles, adheres to, or is faithful to the evidence-based model on which it is based. Fidelity is formally assessed using rating scales of the major elements of the evidence-based model. A toolkit on how to develop and use fidelity instruments is available from the SAMHSA-funded Evaluation Technical Assistance Center at http://tecathsri.org or by calling (617) 876-0426.

Grant: A *grant* is the funding mechanism used by the Federal Government when the principal purpose of the transaction is the transfer of money, property, services, or anything of value to accomplish a public purpose of support or stimulation authorized by Federal statute. The primary beneficiary under a grant or cooperative agreement is the public, as opposed to the Federal Government.

In-Kind Contribution: *In-kind contributions* toward a grant project are non-cash contributions (e.g., facilities, space, services) that are derived from non-Federal sources, such as State or sub-State non-Federal revenues, foundation grants, or contributions from other non-Federal public or private entities.

Logic Model: A *logic model* is a diagrammatic representation of a theoretical framework. A logic model describes the logical linkages among program resources, conditions, strategies, short-term outcomes, and long-term impact.

Practice: A *practice* is any activity, or collective set of activities, intended to improve outcomes for people with or at risk for mental illness and/or substance abuse. Such activities may include direct service provision (e.g., therapy, day treatment), supportive activities (e.g., mentoring, respite), and efforts to improve access to and retention in services, organizational efficiency or effectiveness, community readiness, collaboration among stakeholder groups, education, awareness, training, or any other activity that is designed to improve outcomes for people with or at risk for mental illness or substance abuse.

Practice Support System: This term refers to *contextual factors* that affect practice delivery and effectiveness in the pre-adoption phase, delivery phase, and post-delivery phase, such as a) community collaboration and consensus building, b) training and overall readiness of those implementing the practice, and c) sufficient ongoing supervision for those implementing the practice.

Community Partner: A *community partner* is an individual, organization, constituent group, or other entity that has an interest in and will be affected by a proposed grant project. Community partners in cooperative agreements under this Program may include a wide variety of community representatives, as well as the children and families themselves, each with an interest in the impact or effectiveness of the system of care.

Sustainability: *Sustainability* is the ability to continue a program or practice after SAMHSA grant funding has ended. Grantees should make all efforts to sustain any and all practices established or enhanced through this project.

Target Population: The *target population* is the specific population of people a particular program or practice is designed to serve or reach.

Wraparound Process: *Wraparound* process is an approach to treatment that has evolved over the past 15 years through efforts to help families with the most challenging children function more effectively in the community. More specifically, it is a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes**.**

Essential Elements of Wraparound

1. Wraparound must be based in the community.

2. The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized plan.

3. Families must be full and active partners in every level of the wraparound process.

4. Services and supports must be individualized, built on strengths, and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school and community.

5. The process must be culturally competent, building on the unique values, preferences and strengths of children and families, and their communities.

6. Wraparound child and family teams must have flexible approaches and adequate and flexible funding.

7. Wraparound plans must include a balance of formal services and informal community and family supports.

8. There must be an unconditional commitment to serve children and their families is essential.

9. The plans should be developed and implemented based on an interagency, community-based collaborative process.

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